NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, JUNE 4, 2020
2:00 P.M.

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

BOARD OF DIRECTORS

Paul Yost, M.D., Chair
Ria Berger
Ron DiLuigi
Alexander Nguyen, M.D.
J. Scott Schoeffel
Dr. Nikan Khatibi, Vice Chair
Clayton Chau, M.D.
Supervisor Andrew Do
Lee Penrose
Supervisor Michelle Steel
Supervisor Doug Chaffee, Alternate

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

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

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

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

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

1) **Listen to the live audio at +1 (562) 247-8422 Access Code: 840-006-600 or**
2) **Participate via Webinar at** https://attendee.gotowebinar.com/register/3268515324546419981
3) **rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
None.

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.

MANAGEMENT REPORTS
1. Chief Executive Officer Report
   a. California Proposed State Budget Impact on Medi-Cal
   b. CalOptima's Revised Operating Budget
   c. COVID-19 Response
   d. Mental Health Awareness Month
   e. Health Network Meetings
   f. Board Ad Hoc Committee on Delivery System Evaluation
   g. Prospect Medical Group Expansion
   h. Assemblywoman Sharon Quirk-Silva's Homelessness Update
   i. Real Estate Consultant Projects

CONSENT CALENDAR
2. Minutes
   a. Approve Minutes of the May 7, 2020 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the February 19, 2020 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee; the February 20, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; the December 19, 2020 Special Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee; the February 25, 2020 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee; the March 12, 2020 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee; and the April 9, 2020 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee and Provider Advisory Committee

3. Consider Ratification of Expenditures Related to Emergency Repairs for CalOptima Facilities

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

5. Consider Approval of Proposed Revisions to CalOptima Finance Policies

6. Consider Approval of CalOptima Medi-Cal Directed Payments Policy and Modifications to Claims Administrations Policies and Procedures

7. Consider Approval of the 2019 CalOptima Utilization Management (UM) Program Evaluation and the 2020 CalOptima UM Program

REPORT ITEMS

8. Consider Approval of the CalOptima Fiscal Year 2020-21 Operating Budget

9. Consider Approval of the CalOptima Fiscal Year 2020-21 Capital Budget

10. Consider Approval of Remedial Actions Related to Health Network and Provider Overpayments Arising from Medi-Cal Member Eligibility Reporting Error

11. Consider Actions Related to Intergovernmental Transfer (IGT) 5, 6 and 7 Community Grant Contracts in Response to COVID-19

12. Consider Adopting Resolution Authorizing and Directing Execution of Contract with the California Department of Aging for the Multipurpose Senior Services Program

13. Consider Authorizing and Directing Execution of Amendment to the Agreement with the California Department of Health Care Services for the CalOptima Program of All-Inclusive Care for the Elderly

14. Consider Authorizing Execution of Amendment to Agreement with the California Department of Health Care Services in Order to Continue Operation of the OneCare and OneCare Connect Programs

15. Consider Authorizing Extension and Amendments of the CalOptima Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts

16. Consider Authorizing Modifications to Quality Improvement Policies

17. Consider Approval of Revisions to Finance Policies and Procedures

18. Consider Approving Updates to Policy EE.1103: Provider Education and Training

19. Approve Revised CalOptima Policies AA. 1204: Gifts, Honoraria, and Travel Payments and AA. 1216: Solicitation and Receipt of Gifts to CalOptima

20. Consider Approval of Reimbursement for Necessary Business Expenditures Incurred by Regular Full Time or Part-Time Employees on Temporary Telework in Response to the Public Health Emergency Arising from the Coronavirus (COVID-19) Pandemic

21. Consider Authorizing Extension of State Legislative Advocacy Services Contract

22. Consider Authorizing Amendments to the CalOptima Direct Medi-Cal Primary Care Physician, Specialty Physician, and Clinic Fee-for-Service Contracts, Except Those Involving Providers Affiliated with St. Joseph Health

23. Consider Authorizing Amendments to the CalOptima Direct Medi-Cal Non-Clinic Primary Care Physician Fee-for-Service Contracts for Providers Affiliated with St. Joseph Health

24. Consider Authorizing Amendments to the CalOptima Direct Medi-Cal Clinic Fee-for-Service Contracts with Clinics Affiliated with St. Joseph Health

25. Consider Authorizing Amendments to the CalOptima Direct Medi-Cal Specialist Physician Fee-for-Service Contracts for Providers Affiliated with St. Joseph Health

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

27. Consider Authorization of a Grant Agreement with the County of Orange for Medical Respite Care

28. Consider Authorization of Expenditures Related to Board Membership in the National Association of Corporate Directors for Fiscal Year 2020-21

29. Consider Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year 2020-21

30. Consider Appointments to the CalOptima Board of Directors' Member Advisory Committee

31. Consider Provider Advisory Committee Recommended Appointments to the CalOptima Board of Directors' Provider Advisory Committee

ADVISORY COMMITTEE UPDATES

32. OneCare Connect Member Advisory Committee Update

33. Whole Child Model Family Advisory Committee Update

34. Provider Advisory Committee Update

35. Member Advisory Committee Update

INFORMATION ITEMS

36. Impact of COVID-19 on Quality and Vulnerable Population

37. CalOptima Members Experiencing Homelessness Update

38. April 2020 Financial Summary

39. Compliance Report

40. Federal and State Legislative Advocates Reports

41. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

Webinar Instructions for Joining the Regular Meeting of the CalOptima Board of Directors
June 4, 2020 at 2:00 p.m.

How to Join

1. **Please register for Regular Meeting of the CalOptima Board of Directors on June 4, 2020 2:00 PM PDT at:**
   https://attendee.gotowebinar.com/register/3268515324546419981

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: +1 (562) 247-8422
   Access Code: 840-006-600
   Audio PIN: Shown after joining the webinar

MEMORANDUM

DATE:	May 27, 2020
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, Interim CEO
SUBJECT:	CEO Report — June 4, 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

California Proposed State Budget Would Significantly Alter Medi-Cal Program

On May 14, Gov. Gavin Newsom released a revised FY 2020–21 state budget proposal (May Revise) that accounts for the significant negative impact of COVID-19. The proposed budget totals $203.3 billion, with General Fund spending at $133.9 billion. This represents a decrease of $18.9 billion from the governor's January budget proposal. Below are summaries of key impacts:

- *Medi-Cal Cuts and Changes:* Regarding Medi-Cal, the May Revise increases the budget to $115.3 billion, compared with the January budget proposal of $107.4 billion. This is due to a projected Medi-Cal enrollment increase, peaking at 14.5 million beneficiaries.

  However, to balance the budget, the May Revise includes major Medi-Cal impacts through multiple program cuts and withdrawn or delayed initiatives. Among these are cutting Medi-Cal managed care plan rates by 1.5% for the 18-month bridge period of July 1, 2019–December 31, 2020, and further cuts for Calendar Year 2021; eliminating a dozen optional Medi-Cal benefits and two programs for seniors, Community-Based Adult Services (CBAS) and Multipurpose Senior Services Program (MSSP); redirecting Proposition 56 funds away from supplemental payments and toward program growth; delaying California Advancing and Innovating Medi-Cal (CalAIM); and withdrawing the January proposal to expand Medi-Cal to undocumented seniors. These and other proposals are further summarized in the staff analysis that follows my CEO Report.

  In terms of next steps, the Legislature will hold budget hearings and has until June 15 to pass and submit a final state budget for the governor's approval. Furthermore, the proposals to eliminate the optional benefits, CBAS and MSSP will require federal approval before implementation and could potentially be avoided with an infusion of federal funding.
- *MSSP:* The proposed budget calls for eliminating MSSP no sooner than July 1, 2020, to save approximately $22.2 million statewide. CalOptima has approximately 450 members in MSSP and a staff of 18 dedicated to the program. To address the proposal's potential impact on CalOptima employees, medical and Human Resources leaders met virtually with the MSSP team. They explained that CalOptima is actively engaged in advocating to retain the program, but if a transition is necessary, the priority is retention and moving staff to other open positions at CalOptima as their skills and qualifications allow.
- *CBAS:* The state's proposal to eliminate the CBAS program by January 1, 2021, is generating response from affected organizations, including a request that CalOptima convey to the state that CBAS saves money while positively impacting members' health. CalOptima's state associations, the California Association of Health Plans and Local Health Plans of California,

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are actively engaged in protecting the stability of the Medi-Cal program by advocating for federal funding that would curb the need to cut benefits and programs. In a May 24 hearing of the State Senate Budget and Fiscal Review Committee's health and human services subcommittee, there appears to be a level of support for retaining CBAS and MSSP, but the outcome will be unknown until the budget is approved.

Full Board to Consider Revised Operating Budget With Reduced Administrative Costs
The May 21 Finance and Audit Committee (FAC) meeting included a robust discussion about CalOptima's FY 2020–21 operating budget, with a proposed consolidated deficit of approximately $61.7 million. This is heavily impacted by the May Revise's proposal to cut Medi-Cal capitation rates for the 18-month bridge period of July 1, 2019–December 31, 2020, as well as the upcoming Calendar Year 2021. CalOptima has proposed absorbing the revenue reductions from the May Revise instead of passing them to health networks and fee-for-service providers. However, CalOptima is moving forward with a rate rebasing effort that recommends cuts to Medi-Cal Classic capitation rates and continued right sizing of Medi-Cal Expansion capitation rates, as well as a reduction to OneCare Connect hospital capitation rates. FAC members asked staff to reexamine the proposed consolidated administrative expenses of $166.3 million and make reductions where possible. Therefore, FAC did not approve the operating budget and advised that the full Board consider the revised budget on June 4.

Ongoing COVID-19 Response Focuses on Communication, Collaboration
In the 10 weeks since CalOptima received confirmation of our first COVID-19 case, staff remains committed to the comprehensive, collaborative response required of us as the health plan that covers nearly 25% of all Orange County residents. As of May 26, CalOptima has received reports of 605 positive cases, 355 hospitalizations and 16 deaths among our members.

- *Member Communications:* CalOptima recently enhanced our COVID-19 member section on the website here. It was updated and reorganized for ease of use, and it is available in all seven threshold languages.
- *Provider Communications:* One of CalOptima's top priorities amid the pandemic is keeping providers informed about myriad regulatory changes and the latest news. CalOptima distributes material electronically and via fax. Dozens of updates were added in May. View the provider section here.
- *Orange County Nursing Home COVID-19 Prevention Team Program:* There is widespread concern about the heavy toll COVID-19 is having in nursing homes, and CalOptima is proudly promoting a new program to reduce infection rates. After your Board's May 7 approval of CalOptima's collaborative effort with UCI and Orange County Health Care Agency, we distributed a media release that garnered immediate attention. The Orange County Register ran articles on May 8 and May 22, while the Los Angeles Times published a piece on May 14. NBC's Vikki Vargas did a TV news segment on May 13 viewable here.
- *Komen Orange County Webinar:* On May 26, Executive Director of Quality and Population Health Betsy Ha participated in the Komen OC webinar educational series "Caring Through COVID-19 Together," along with Komen CEO Megan Klink. Ha discussed Medi-Cal coverage for breast health and cancer, including details about the Breast and Cervical Cancer Treatment Program and the importance of continuing to get mammograms.
- *Clinical Field Teams (CFTs):* CalOptima appreciates the ongoing partnership of our CFT organizations in serving individuals experiencing homelessness amid the pandemic. Data from mid-April to mid-May shows that activity remains constant. CFTs treated 40 patients,

and 24 were CalOptima members. Twenty referrals came from shelters, and the other half were from county and city outreach teams. COVID-19 drove a transition to telehealth visits with CFTs, and 16 visits have been completed using a telehealth approach since April.

- *Return to 505 Building:* With California beginning to relax the Stay-at-Home Order based on certain criteria, CalOptima is starting internal discussions regarding employees returning to the building. Currently, there is no specific timeframe for this, and we are gathering information shared by other health plans during collaborative calls. The executive team recognizes that significant short- and long-term modifications to our workspace will be necessary, including perhaps maintaining a higher percentage of teleworking staff. I will keep your Board informed as we develop a plan.

Mental Health Awareness Month Highlights Intensified Needs During Pandemic
May is national Mental Health Awareness Month, and CalOptima has amplified our longstanding support for this effort that promotes mental wellness. We have conducted a variety of activities to raise awareness among staff, members and the public. Internally, CalOptima has distributed many resources and engagement opportunities to staff via email. Our social media channels have carried regular messages about how to get help when needed and/or take action to boost wellness. On May 31, Edwin Poon, Ph.D., director of Behavioral Health Services, will be featured during a 30-minute interview about mental health during the COVID-19 pandemic on Tammy Trujillo's Community Cares program, on Angels Radio (KLAA-AM 830).

CalOptima Holds Key Meetings With Health Network Partners
The pace of change requires ongoing engagement with our health network partners, and this month, CalOptima invited their participation in two key meetings that provided information about financial, operational and medical topics.

- Health Network CEO Meeting — On May 19, CalOptima engaged health network leaders with updates about our Homeless Health Initiatives and COVID-19 response, but spent the majority of the time discussing detailed financial issues, including the Medi-Cal and OneCare Connect rate rebasing process, CalOptima's FY 2020–21 budget, and the OneCare Connect/OneCare risk adjustment overreporting reconciliation project.
- Health Network Forum — On May 21, CalOptima's health networks received a variety of updates essential to ongoing collaboration and operation. Staff addressed contracting changes, COVID-19's impact on quality reporting, the expanded office hours initiative, continuity of care for Whole-Child Model and Health Homes Program status. The forum also spent considerable time covering the May Revise and CalOptima's FY 2020–21 budget.

Board Ad Hoc Committee on Delivery System Evaluation Holds First Meeting
On May 18, the Board ad hoc committee formed to consider the delivery system evaluation met for the first time. Pacific Health Consulting Group and Milliman Inc. delivered a comprehensive final report that contained a variety of recommendations, and the ad hoc will be studying the various strategies to enhance CalOptima's delivery system. The ad hoc plans to meet every other week, with a goal of bringing selected recommendations back to the full Board for action and implementation. The final report is available as part of the February 6 Board materials here.

Prospect Medical Group to Acquire Additional Physician Practices to Expand Network
Contracted health network Prospect Medical Group announced it is expanding through the acquisition of three independent physician practices in Southern California. Prospect plans to buy certain assets of CalCare IPA, Los Angeles Medical Center IPA and Vantage Medical

Group. The transaction will double Prospect's network to more than 20,000 doctors. Prospect serves about 34,500 CalOptima Medi-Cal members and 2,200 OneCare Connect members.

CalOptima to Participate in Assemblywoman's Update on Homelessness
On May 29, Assemblywoman Sharon Quirk-Silva is hosting an interactive, virtual update on Orange County's homelessness issue in light of the pandemic. I will participate on behalf of the agency by sharing information regarding our Homeless Health Initiatives and services for the local homeless population.

Projects for Real Estate Consultant Reprioritized
Earlier this year, CalOptima engaged real estate consultant Newmark Knight Frank for work in three main areas: office space and parking assessment, Program of All-Inclusive Care for the Elderly (PACE) lease renewal, and CalOptima development rights evaluation. Due to the COVID-19 pandemic, CalOptima has reprioritized these tasks. While the consultant will continue to monitor the local commercial real estate market, management will reevaluate future office space and parking needs based on the changing conditions of increased employee telework and potential membership growth. Therefore, this aspect of the consultant's work has been postponed until after the internal review is complete. The consultant is moving forward with work on the PACE lease, which expires December 2021, by starting negotiations with the PACE landlord. The goal is to bring a proposal to the Board for review later this year. Regarding the development rights for the 505 City Parkway West property, CalOptima has already had an initial meeting with the City of Orange planning managers and identified a two-phase approach. First, we will seek an extension of the existing, unmodified development rights past the October 2020 expiration. In the second phase, with assistance from the consultant, staff will evaluate other development options and bring those recommendations to the Board for consideration.

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2020-21 California State Budget May Revise Analysis

May 2020

Overview

On May 14, 2020, Governor Newsom released a revised Fiscal Year (FY) 2020–21 state budget proposal (May Revise). In response to the COVID-19 pandemic, the Department of Finance calculated a budget shortfall of approximately $54.3 billion for the next FY.[1] The State of California is constitutionally obligated to pass a balanced budget by June 15, 2020, which will be enacted on July 1, 2020. Therefore, the May Revise proposes drastic changes to the upcoming budget cycle to offset the current shortfalls.

The May Revise proposes a total state budget of $203.3 billion, with General Fund (GF) spending at $133.9 billion.[2] This represents an overall decrease of $18.9 billion from the Proposed January Budget, a decrease of 8.5 percent and a 9.4 percent decrease from the Budget Act of 2019.[3]

As the State of California faces a multiyear approach to recovering from an historical recession, Governor Newsom committed to balancing the budget while focusing on core values, such as public health, public education, public safety, and those hit hardest by COVID-19. Specific to public health, Governor Newsom's May Revise focuses on:

- An increased number of Medi-Cal beneficiaries;
- Withdrawing proposed initiatives;
- Reducing health care spending costs;
- Reducing managed care capitation rates; and
- Providing resources to address the COVID-19 pandemic.

The Medi-Cal Budget

Even with a decrease in GF dollars, the Medi-Cal spending budget proposed for FY 2020–21 receives an overall increase of $8.3 billion, or 7.1 percent, when compared to the January Proposed Budget.

FY 2020–21 Medi-Cal Spending

	January Proposal	May Revision
General Fund	$26.4 billion	$23.7 billion
Federal Funds	$67.5 billion	$73.8 billion
Other	$13.4 billion	$18.1 billion
Overall Budget	**$107.3 billion**	**$115.6 billion**[4]

The federal portion of the Medi-Cal budget is funded through several avenues. For original Medi-Cal, also known as Medi-Cal classic, there is a 50/50 federal/state funding match. For the Medi-Cal expansion population, there is an enhanced federal match (90/10 for 2020 and subsequent calendar years).[5] For the Children's Health Insurance Program population, which was carved in to Medi-Cal in 2013, there is currently an 88/12 match.

Of note, and in response to the COVID-19 pandemic, the Department of Health Care Services (DHCS) is projecting a significant increase to the Medi-Cal caseload, peaking at 14.5 million by July 2020, due to COVID-19 related unemployment. This represents an increase of approximately 1.5 million beneficiaries when compared to pre-COVID-19 levels. As authorized by the Families First Coronavirus Response Act, the Centers for Medicare & Medicaid Services (CMS) provided the state with an emergency increase in the Federal Medical Assistance Percentages (FMAP) for Medicaid of 6.2% (California's FMAP would be increased from 50% to 56.2%). FMAP funds are to be utilized for expenses, such as emergency paid sick leave and unemployment insurance, COVID-19 testing at no cost, food aid, and other provisions related to COVID-19.

Eliminating Future Health Care Proposals

The Newsom Administration has indicated that the state is not in a fiscal position to increase rates or expand programs given the drastic budget impacts of the COVID-19 Recession. To reduce upcoming health care spending costs and support a balanced budget, the following proposals were withdrawn from the Governor's January Proposed Budget, for a savings of $995.7 million total funds ($592.3 million GF) for FY 2020–21:

Removed Proposed Health Care Programs

Proposed Program	Cost Savings
California Advancing and Innovating Medi-Cal (CalAIM)	$695 million ($347 million GF)
Full- Scope Medi-Cal Expansion to Undocumented Older Adults	$112.7 million ($87 million GF)
Medi-Cal Aged, Blind, and Disabled Income Level Expansion	$135.5 million ($67.7 million GF)

340B Supplemental Payment Pool	$52.5 million ($26.3 million GF)
Postpartum Mental Health Expansion	$34.3 million GF
Hearing Aids	$5 million GF
2019 Budget Act Reversions	$25 million

Reducing & Eliminating Medi-Cal Benefits

Months after the restoration of certain Medi-Cal optional benefits that were cut to balance the budget following the Great Recession, the Governor has proposed the elimination of those benefits, and more. Governor Newsom advised that these proposed reductions may be staved off or reinstated if the federal government provides sufficient funding to restore them. The May Revise assumes receipt of no additional federal funds, and makes significant reductions in an effort to balance the state budget:

Removed Existing Health Care Programs[6]

Proposed Program	Cost Savings
Adult Dental and Other Optional Benefits eliminated, effective no sooner than July 1, 2020:[7] • Podiatry • Acupuncture; • Optometry; • Nurse anesthetist services; • Audiology; • Incontinence creams and washes; • Speech therapy; • Optician/optical lab; • Occupational and physical therapy; • Pharmacist-delivered services;[8] • Screening, brief intervention and referral to treatments for opioids and other illicit drugs in Medi-Cal; and • Diabetes prevention program services.	$54 million GF
Proposition 56 Adjustments eliminated, effective July 1, 2020:[9] • Supplemental payments for physicians, dental, family health services, developmental screenings, non-emergency medical transportation; • Value-based payments; • Behavioral Health Integration Incentive Program; • Pediatric hospital payments; and • Loan repayments for physicians and dentists	$1.2 billion Proposition 56 funds shifted
Community Based Adult Day Services (CBAS) eliminated, effective January 1, 2021[10]	$106 million GF
Multipurpose Senior Services Program (MSSP) eliminated, no sooner than July 1, 2020[11]	$22.2 million GF
Federally Qualified Health Centers (FQHC) Payment Adjustments	$100 million ($50 million GF)
Estate Recovery	$16.9 million GF
Martin Luther King, Jr. Hospital	$8.2 million GF
County Administration	$31.4 million ($11 million GF)
Family Mosaic Project	$1.1 million GF

The removal of certain covered benefits would require federal approval from the CMS. The State cut certain optional benefits to balance the budget during the last recession, and at that time the CalOptima Board of Directors made the decision to continue to provide podiatry services, audiology exams, speech therapy and chiropractic services at CalOptima's cost.[12]

Furthermore, Proposition 56 Funds are still required to support Medi-Cal benefits. $1.2 billion in Proposition 56 funding would be shifted to support growth in the Medi-Cal program.[13] Additionally, $67 million will continue to support rate increases for home health, pediatric day health care facilities, pediatric sub-acute facilities, AIDS waiver supplemental payments, already awarded physician and dentist loan repayments, and trauma screenings & trainings.

Managed Care Capitation Rates

The May Revision proposes various changes to the way that managed care capitation rates are determined. These changes include various acuity, efficiency, and cost containment adjustments. These adjustments would be effective for the managed care rate year starting January 1, 2021, for a GF savings of $91.6 million in 2020–21 and $179 million in 2021-22, growing thereafter. Additionally, the May revision assumes a 1.5 percent rate reduction and implementation of a risk corridor calculation for the period July 1, 2019 through December 31, 2020, which is referred to as the 18-month bridge period, and implement "efficiencies" in the development of managed care plan rates, for GF savings of $182 million in 2020–21.[14]

In-Home Supportive Services

Additional cost savings, pending federal financial support, are proposed to come from the In-Home Supportive Services (IHSS) budget. The May Revise seeks to reduce the number of hours provided to IHSS beneficiaries, effective January 1, 2021, by 7 percent, generating a savings to the GF of $205 million. Additionally, the May Revision freezes IHSS county administration funding at

the FY 2019–20 level. This proposal would result in a savings of $12.2 million GF for FY 2020–21.

Housing the Homeless

California has experienced significant increases in the number of unsheltered individuals in recent years, a problem inextricably linked to the state's underproduction of affordable housing. In the Governor's January Budget Proposal and during the 2020 State of the State Address, Governor Newsom pledged $750 million GF for homeless housing and services.[15] The COVID-19 Recession has substantially altered the state's broad goals to reduce homelessness. Funding to provide housing and support to help stabilize and prevent homelessness will need to be modified. Therefore, the May Revise proposes to expand the state's Project Roomkey. This would be accomplished by shifting the $750 million GF to be used for the of purchase Project Roomkey hotel/motel rooms. The state also plans to continue funding the Homeless Coordinating and Financing Council Administrative Resources, which will cost $1.5 million GF.

COVID-19 Funding

The May revision proposes specific use of disbursements from the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act, signed into law on March 27, 2020. The state's response to COVID-19 includes strengthening local public health preparedness and responses and support for health and human services at the local level.

CARES Act Funds

Program	Funding Amount
Protection of public health and public safety	$3.8 billion
Funding to counties for public health	$1.3 billion
Funding for cities for public health	$450 million

Additionally, to support COVID-19 responses in Skilled Nursing Facilities (SNFs), the May Revision maintains the nursing facility reform framework proposed in the Governor's January Budget. In addition, the May Revision assumes a rate increase of 10 percent for SNFs for four months during the COVID-19 pandemic, at a GF cost of $41.6 million in FY 2020-2021. On May 13, 2020, California received approval from CMS to implement this increase.

Pharmacy Carve-Out

One of the Governor's proposals in the FY 2019–20 budget with the greatest impact to CalOptima and Medi-Cal managed care plans is the carve-out of prescription drugs from Medi-Cal managed care and the return of this benefit to fee-for-service (FFS), no sooner than January 1, 2021. The May Revision assumes a January 1, 2021 implementation of the Medi-Cal pharmacy carve-out. The savings estimate was adjusted slightly downward from the Governor's January Budget, as the carve out will not be implemented for Cal MediConnect dual contracts.[16]

Other Adjustments

Other adjustments in the Medi-Cal budget account for revenue increases from the CARES Act enhanced FMAP, MCO Tax, and a new E-Cigarette Tax. Additional savings are generated by shifting County Medical Service Program reserve funding to offset general fund costs, and by not restoring a drug rebate volatility reserve. Combined, these adjustments represent a decrease of $7.04 billion GF spending that otherwise would have accounted for in the 2020–21 Budget. Other adjustments are as follows:

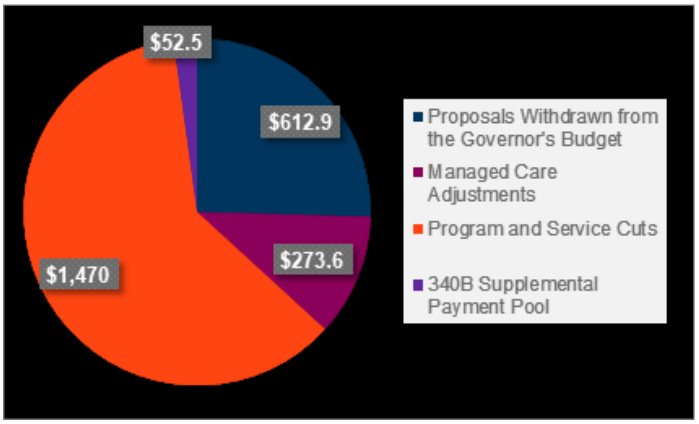
Other Adjusted Funds

Proposed Program	Cost Savings
Enhanced FMAP	$5.1 billion GF
MCO Tax	$1.7 billon GF
Drug Rebate Reserve; Due to not restoring a drug rebate volatility reserve	$181 million GF
County Medical Services Program	Shift of $50 million in reserves
E-cigarette Tax	$10 million GF

Total Spending Cuts

The table below demonstrates total GF savings for FY 2020–21 of $2.34 billion as a result of the withdrawn proposals, program and service cuts, and managed care capitation adjustments.

Removal of Proposed Programs (In millions)



Next Steps

The negotiations between the legislature and the Governor will continue in the coming weeks, as budget legislation implementing the Governor's proposals is introduced, modified and debated. The State Assembly will review the May Revision on May 19, 2020 and the State Senate will review the revised budget on May 23, 2020. The Legislature has until June 15 to pass and submit a final state budget for the Governor Newsom's approval. CalOptima will closely follow these ongoing budget discussions and provide updates regarding issues that have an impact on the agency.

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities in Orange County. 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).

If you have any questions regarding the above information, please contact:

TC Roady
Director, Regulatory Affairs and Compliance
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Endnotes

[1] The COVID-19 Pandemic and California's Budget Outlook, Department of Finance, May 7, 2020
[2] California State Budget May Revision Fiscal Year 2020-2021
[3] California State Budget Proposal Fiscal Year 2020-2021
[4] Department of Health Care Services: 2020-21 May Revision Highlights
[5] Health Insurance & Health Reform Authority: California and the ACA's Medicaid Expansion, January 10, 2020
[6] California State Budget May Revision Fiscal Year 2020-2021, Pages 61-62
[7] DHCS Medi-Cal Estimates, Regular Policy Change 257
[8] DHCS Medi-Cal Estimates, Regular Policy Change 51
[9] DHCS Medi-Cal Estimates, Regular Policy Changes 146, 199, and 259
[10] DHCS Medi-Cal Estimates, Regular Policy Change 257
[11] DHCS Medi-Cal Estimates, Regular Policy Change 38
[12] CalOptima Board Action Agenda Referral: Approve CalOptima's Subsidization of Certain Optional Medi-Cal Benefits to be Cut by the State of California, June 4, 2009
[13] DHCS Medi-Cal Estimates, Regular Policy Change 264
[14] DHCS Medi-Cal Estimates, Regular Policy Changes 255 and 258
[15] Governor Newsom State of the State Address, February 19, 2020
[16] DHCS Medi-Cal Estimates, Regular Policy Change 52

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

May 7, 2020

A Regular Meeting of the CalOptima Board of Directors was held on May 7, 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 Paul Yost, M.D. called the meeting to order at 2:00 p.m. Chair Yost led the Pledge of Allegiance.

ROLL CALL

Members Present: Dr. Nikan Khatibi, Vice Chair; (at 2:03 p.m.) Ria Berger; Clayton Chau, M.D.; (non-voting) Ron DiLuigi; Supervisor Andrew Do; (at 2:03 p.m.) Alexander Nguyen, M.D.; Lee Penrose; Scott Schoeffel; Supervisor Michelle Steel (at 2:30 p.m.); Paul Yost, M.D., Chair
(All members at teleconference locations except the Chair)

Members Absent: None

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

Chair Yost virtually welcomed Clayton Chau, M.D., Director of the Orange County Health Care Agency (HCA) and the HCA Representative on the CalOptima Board of Directors.

Chair Yost announced that Agenda Item 3 is being continued for further study and will be brought back to the Board at a future meeting.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Interim Chief Executive Officer (CEO) Richard Sanchez highlighted items in his report and thanked staff for its work in developing COVID-19 communications in our members' seven threshold languages that are now available on CalOptima's website and for responding to an urgent data request from the Department of the Health Care Services.

PUBLIC COMMENTS

There were no requests for public comment.

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CONSENT CALENDAR

2. Minutes

a. Approve Minutes of the April 2, 2020 Regular Meeting of the CalOptima Board of Directors; the Minutes of the April 16, 2020 Special Meeting of the CalOptima Board of Directors

b. Receive and File Minutes of the February 27, 2020 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee | *Rev. 6/4/2020*

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 8-0-0; Supervisor Steel absent)***

REPORT ITEMS

3. Consider Approval of New CalOptima Policy AA.1500: Medical Respite Program and Authorization of Related Amendment of the County Coordination and Provision of the Public Health Care Services Contract

This item was continued to a future meeting.

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

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO) to modify the following existing medical policies and procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows: 1.) GG.1804: Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B); and 2.) MA.6104 Opioid Medication Utilization Management (Motion carried 8-0-0; Supervisor Steel absent)***

5. Consider Approval of CalOptima's New FQHC/RHC Pay for Performance Policy and Modified Quality Improvement Policies

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors approved modifications to the following policies pursuant to CalOptima's annual review process: a.) GG.1656: Quality Improvement and Utilization Management Conflicts of Interest; b.) GG.1620: Quality Improvement Committee; and 2.) Approved CalOptima Policy GG.1660: Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Financial Incentives and Pay for Performance Payments to comply with the Department of Health Care Services (DHCS) guidance (Motion carried 8-0-0; Supervisor Steel absent)***

Back to Agenda

6. Consider Actions Related to CalOptima's Primary Care Engagement and Clinical Documentation Integrity Program for Qualified Providers Contracted with the CalOptima Community Network for the OneCare Connect Program

Staff noted a correction to the recommended actions to remove the references to contracts and contract amendments.

Betsy Ha, Executive Director, Quality and Population Health Management, introduced the item noting that the Centers for Medicare & Medicaid Services (CMS) uses diagnosis data to assess program quality and calculate revenue based on risk. Most health plans use Medicare Attestation Programs to improve quality and member care. This also improves HEDIS scores since the providers are seeing patients and sending over accurately coded data.

Director Schoeffel commented that it seems we are incentivizing providers with additional dollars for responsibilities the providers should being doing per their contracts.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors 1.) Approved CalOptima Policy CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for Community Care Network Contracted Providers, authorize the Chief Executive Officer (CEO) to establish a OneCare Connect (OCC) CalOptima Community Network (CCN) Primary Care Engagement and Clinical Documentation Integrity Program, and approve disbursement methodology; ~~and authorize the CEO, with the help of Legal Counsel, to execute agreements and/or contract amendments as necessary for implementation~~; and 2.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose. (Motion carried 8-1-0; Supervisor Steel voting no)***

Amended 5/7/2020

7. Consider Actions Related to Support Orange County Nursing Facilities During the Coronavirus (COVID-19) Pandemic

Emily Fonda, M.D., Deputy Chief Medical Officer, introduced the item, noting that the staff recommendation relates to a newly formed Orange County COVID Nursing Home Prevention Program. The program was developed by the University of California-Irvine (UCI) with the primary goals of engaging nursing homes to undergo intensive COVID-19 infection prevention training to provider greater depth and assurance of infection prevention readiness in a key subgroup that can serve as a high-fidelity resource; and support serologic and point prevalence PCR testing of residents and staff in select nursing homes to inform trajectory toward spread and immunity. Dr. Fonda also noted that a number of the COVID cases in nursing homes are CalOptima members, and the UCI program is intended to help CalOptima members and residents in Orange County's nursing homes.

Back to Agenda

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors 1.) Authorized the CEO, with the assistance of Legal Counsel, to enter into a Grant Agreement with the Regents of the University of California at Irvine (UCI) to provide funding to support the Orange County COVID Nursing Home Prevention Program, contingent upon equal financial participation from the Orange County Health Care Agency (OCHCA); and 2.) Approved the recommended allocation of intergovernmental transfer (IGT) 9 funds in the amount not to exceed $629,723 to support the Orange County COVID Nursing Home Prevention Program. (Motion carried 9-0-0)***

8. Consider Authorizing Virtual Care Strategy and Roadmap as Part of Coronavirus Disease (COVID-19) Mitigation Activities and Contract with Mobile Health Interactive Text Messaging Services Vendor

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors 1.) Approved Virtual Care Strategy and Roadmap; 2.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to contract with vendor mPulse Mobile, a Mobile Health Interactive Text Messaging Services vendor; and 3.) Approved the recommended allocation of intergovernmental transfer (IGT) 9 funds not to exceed $3.9 million for a three-year period to provide a text messaging solution for all CalOptima member communications. (Motion carried 9-0-0)***

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

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to contract with a: 1.) Virtual care solution provider for PACE members recommended by staff through an informal bidding process for the period of May 1, 2020, through June 30, 2020, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed $9,500; and 2.) Mobile phlebotomy services provider for blood draw services in PACE member homes for the period of April 1, 2020, through June 30, 2020, and authorized unbudgeted expenditures from existing reserves in an amount not to exceed $12,000. (Motion carried 9-0-0)***

10. Authorize Amendment to Medi-Cal Ancillary Contracts for Skilled Nursing Facilities

Director Schoeffel did not participate in this item due to potential conflicts of interest. Supervisor 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 Chair Yost, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend Medi-Cal Ancillary contracts for all Skilled Nursing Facilities (SNF), to standardize and, in aggregate, increase the rates effective***

June 1, 2020. (Motion carried 7-0-1; Supervisor Do abstained; Director Schoeffel recused)

11. Consider Approval of Resolution Renaming Seats on the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors Adopted Resolution No. 20-0507-01, to rename two Member Advisory Committee (MAC) Representative seats as follows: 1) Renamed seat for Medically Indigent Persons Representative to Medical Safety Net Representative; 2) Renamed seat for Persons with Mental Illness Representative to Mental/Behavioral Health Representative; and 3) Authorized updates to CalOptima Policy AA.1219a: Member Advisory Committee to reflect the recommended changes. (Motion carried 9-0-0)***

12. Consider Authorizing Contract with an Executive Search Firm for Chief Executive Officer Recruitment

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

No Action Taken: ***After considerable discussion, Supervisor Do made a motion, to defer this item until after the new Board was seated in August 2020. A roll call vote was taken. (Motion failed; 5-4-0; Chair Yost, Vice Chair Khatibi, Director DiLuigi, Director Nguyen and Director Penrose voting no; Director Berger, Supervisor Do, Director Schoeffel and Supervisor Steel voting yes)***

After further discussion, the Board took another roll call vote, to approve Witt Kieffer as the Executive Search Firm.

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors 1.) Authorized staff, consistent with the Board-approved Purchasing Policy, to enter into a contract with the assistance of Legal Counsel, with~~ either:*** ***Witt Kieffer and include a provision to reduce fees should the Board appoint the Interim Chief Executive Officer (CEO) as the permanent CEO prior to 120 days after contract execution.~~ ; or Korn Ferry International and include a carve out provision to reduce fees should the Board appoint the interim CEO as the permanent CEO at any time during the recruitment.*** ***(Motion carried; 5-4-0; Chair Yost, Vice Chair Khatibi, Director DiLuigi, Director Nguyen and Director Penrose voting yes; Director Berger, Supervisor Do, Director Schoeffel and Supervisor Steel voting no)***

Amended 5/7/2020

13. Consider Recommendations for Expenditures Previously Approved Towards Support of CalOptima's Participation in Community Events Impacted Due to COVID-19 Pandemic

Staff noted that the policy number referenced in the recommended action should be Policy AA.1223 instead of AA.1123.

Back to Agenda

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors 1.) Authorized CalOptima to provide organizers of community events that have been cancelled or postponed due to the COVID-19 pandemic the option of either refunding CalOptima's prepayments or, alternatively, applying CalOptima's prepayments to one or more future event(s) provided that the events: a.) Occur on or before June 30, 2021; b.) Meet the eligibility criteria described in Policy AA.1223 ~~1123~~: Participation in Community Events by External Entities, and c.) Are approved for CalOptima's participation by CalOptima's Chief Executive Officer (CEO). 2.) Made a finding that application of prepayments to one or more future event(s) meeting these criteria are for an acceptable public purpose in support of CalOptima's community partners during the COVID-19 pandemic and are in furtherance of CalOptima's mission and statutory purpose; and 3.) Authorized the CEO, with the assistance of Legal Counsel, to execute agreements as necessary for CalOptima's participation in the future events. (Motion carried 9-0-0)***

Amended 5/7/2020

ADVISORY COMMITTEE UPDATES

16. Joint Member Advisory Committee and Provider Advisory Committee Updates

John Nishimoto, O.D., PAC Chair and Christine Tolbert, MAC Chair, provided updates on the Joint MAC/PAC meeting that was held on April 9, 2020. Dr. Nishimoto and Ms. Tolbert also updated the Board on activities on their respective committees including recruitment for open seats on the PAC and the recent MAC appointment approved at today's Board meeting.

INFORMATION ITEMS

17. Introduction to the FY 2020-21 CalOptima Budget:

Ms. Huang presented an overview of the FY2020-21 Operating and Capital budgets, noting that CalOptima had received updated information from the State. Based on that information, staff plans to revise the budget assumptions prior to presenting the proposed budgets to the Finance and Audit Committee in May ahead of presenting the budgets to the Board for final approval on June 4, 2020.

Chair Yost noted that staff has done a thorough job in preparing the remaining information items and asked fellow Board Members if they had any specific questions on any of the items. Hearing none, the following agenda items were accepted as presented.

18. March 2020 Financial Summary
19. Compliance Report
20. Federal and State Legislative Advocates Reports
21. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Board Members welcomed Dr. Chau to the CalOptima Board of Directors.

ADJOURNED TO CLOSED SESSION

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The Board of Directors adjourned to closed session at 4:23 p.m. pursuant to Government Code section 54956.87, subdivision (b), Health Plan Trade Secrets – OneCare and OneCare Connect.

The Board reconvened to open session at 4:53 p.m. with no reportable actions taken.

A quorum was re-established.

14. Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2021 and Execute Contract with the Centers for Medicare & Medicaid Services; Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement (to follow Closed Session)

Director Schoeffel did not participate in this item due to potential conflicts of interest. Supervisor 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 Chair Yost, seconded and carried, the Board of Directors authorized the Chief Executive Officer to submit the Calendar Year 2021 OneCare bid, make minor changes to the final bid as necessary to address CMS feedback, and execute the OneCare Contract with CMS; and authorized the CEO to amend the OneCare Health Network Contracts and take other actions as necessary to implement. (Motion carried 5-0-1; Supervisor Do abstained, Director Schoeffel recused; Vice Chair Khatibi and Supervisor Steel absent)***

15. Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Connect Bid for Calendar Year 2021 and Execute Three-way Contract with the Centers for Medicare & Medicaid Services and the Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare Connect Health Network Contracts and Take Other Actions as Necessary to Implement (to follow Closed Session)

Director Schoeffel did not participate in this item due to potential conflicts of interest. Supervisor 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 Chair Yost, seconded and carried, the Board of Directors authorized the CEO to submit the Calendar Year 2021 OneCare Connect bid for supplemental benefits to the plan benefit package, make minor changes as necessary to address CMS feedback, and sign the Three-Way Contract with DHCS and CMS; and authorize the CEO to amend and/or execute OneCare Connect Health Network Contracts and take other actions as necessary to implement. (Motion carried 5-0-1; Supervisor Do abstained, Director Schoeffel recused; Vice Chair Khatibi and Supervisor Steel absent)***

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ADJOURNMENT
Hearing no further business, the meeting was adjourned at 5:00 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: *June 4, 2020*

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS'
QUALITY ASSURANCE COMMITTEE

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 19, 2020

CALL TO ORDER
Chair Paul Yost called the meeting to order at 3:00 p.m. Director Nguyen led the pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Alexander Nguyen M.D.

Members Absent: Dr. Nikan Khatibi

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel, Betsy Ha, Executive Director, Quality and Population Health Management; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Sharon Dwiers, Clerk of the Board

Chair Yost reordered the Agenda to hear Information Item 10. PACE Member Advisory Committee Update, and the Public Comments before the Consent Calendar.

INFORMATION ITEMS

10. PACE Member Advisory Committee Update
Elizabeth Lee, Director of PACE, provided an overview of the activities at the PACE Member Advisory Committee meeting held on January 2020.

PUBLIC COMMENTS
Patrick McGee, PACE Member Advisory Committee Member – Oral re: PACE gym/physical therapy equipment.

CONSENT CALENDAR

1. Approve the Minutes of the December 13, 2019 Special Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Chair Yost, seconded and carried, the Committee approved the Minutes of the December 13, 2019 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee. (Motion carried 2-0-0; Director Khatibi absent)***

Back to Agenda

REPORTS

2. Receive and File 2019 CalOptima Quality Improvement Program Evaluation

Betsy Ha, Executive Director, Quality and Population Health Management, reviewed the 2019 Quality Improvement Program Evaluation. Ms. Ha highlighted several accomplishments including maintaining Commendable accreditation status from the National Committee for Quality Assurance (NCQA), improving performance in 2019 on 42 of the 62 threshold HEDIS measures, and implementing a comprehensive health network Pay for Value Performance Measurement Program. Ms. Ha also reviewed several opportunities for improvement including achieving a 4.5 overall NCQA Health Plan rating, implementing member and provider incentives for specific quality measures, evaluating the effectiveness with HEDIS measures in 2020, and improving the exchange of hospital data.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee received and filed the 2019 CalOptima Quality Improvement Program Evaluation. (Motion carried 2-0-0; Director Khatibi absent)***

3. Consider Recommending Board of Directors' Approval of the CalOptima 2020 Quality Improvement Program and 2020 Quality Improvement Work Plan

Ms. Ha presented proposed revisions to the 2020 Quality Improvement Program and the 2020 Quality Improvement Work Plan. The recommended changes are designed to better review, analyze, implement, and evaluate components of the QI Program and Work Plan. The changes are also necessary to meet requirements of CalOptima's regulators, the Centers for Medicare & Medicaid Services (CMS), and the Department of Health Care Services (DHCS), as well as NCQA accreditation standards.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee Recommended Board of Directors' Approval of the recommended revisions to the 2020 Quality Improvement Program and 2020 Quality Improvement Work Plan. (Motion carried 2-0-0; Director Khatibi absent)***

4. Receive and File 2019 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement (QAPI) Plan Evaluation

Miles Masatsugu, M.D., Medical Director PACE, reviewed the 2019 PACE Quality Assessment and Performance Improvement Plan Evaluation. Dr. Masatsugu highlighted several 2019 accomplishments including successful DHCS Level of Care (LOC) audits, increased program growth to 393 participants, of which 63 receive services at Alternative Care Setting (ACS) sites, completion of three Quarterly Initiatives (Program Growth, Participant Care Plans, and Participant Triage). Dr. Masatsugu also reviewed opportunities for improvement, which include: improving the quality of care for participants, ensuring the safety of clinical care, and improving participant experience. Dr. Masatsugu also mentioned that each year all areas continue to improve as the PACE analyzes the data and addresses any deficiencies, which improves the outcomes.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee received and filed the 2019 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement (QAPI) Plan Evaluation. (Motion carried 2-0-0; Director Khatibi absent)***

Back to Agenda

5. Recommend Board of Directors' Approval of the 2020 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Dr. Masatsugu reviewed the proposed 2020 PACE Quality Improvement Plan Description and PACE Quality Improvement Plan.

Action: ***On motion of Chair Yost, seconded and carried, the Committee recommended Board of Directors' approval of the 2020 CalOptima PACE Quality Improvement (QI) Plan. (Motion carried 2-0-0; Director Khatibi absent)***

6. Consider Recommending Board of Directors' Approval of Calendar Years 2020 and 2021 Health Network Medi-Cal Pay for Value Program Payment Methodology Incorporating the Health Network Quality Rating Methodology

Ms. Ha presented an overview of Calendar Years 2020 and 2021 Health Network Medi-Cal Pay for Value Program Payment Methodology.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of CY 2020 and 2021 Health Network Medi-Cal Pay for Value (P4V) Program Payment Methodology incorporating the Health Network Quality Rating (HNQR) methodology for the Measurement Years effective January 1, 2020 Through December 31, 2021. (Motion carried 2-0-0; Director Khatibi absent)***

7. Consider Recommending Board of Directors Approval of Calendar Years 2020 and 2021 Health Network OneCare Connect Pay for Value Program Payment Methodology

Ms. Ha noted that there was no change in the methodology for the OneCare Connect program.

Action: ***On motion of Chair Yost, seconded and carried, the Committee recommended Board of Directors' approval of Calendar Years 2020 and 2021 Pay for Value Program for OneCare Connect Line of Business, which defines measures and allocations for performance and improvement for the Measurement Years (MY) effective January 1, 2020 through December 31, 2021. (Motion carried 2-0-0; Director Khatibi absent)***

8. Consider Recommending Board of Directors' Allocation of Intergovernmental Transfer (IGT) 9 Funds

Candice Gomez, Executive Director, Program Implementation, provided an update on the Allocation of IGT 9 Funds. It was noted that beginning with the IGT 8 through 10 these funds are counted as part of the capitation revenue CalOptima receives from the DHCS, so any expenditure of these IGT funds that do not qualify as medical expenses become part of CalOptima's Administrative Loss Ratio (ALR). Ms. Gomez reviewed the four primary focus areas: Member Access and Engagement – $6.5 million; Quality Performance - $3.4 million; Data Exchange and Support - $2.0 million, and Other Identified Priority Areas $33.1 million. Ms. Gomez also noted that the focus area of Other Identified Priority Areas includes support for the Whole Child Model (WCM) Program, which is projected to generate an operating loss of $31.1 million for FY 2019-20.

Back to Agenda

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended that the Board of Directors' 1) Approve the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives for quality performance, access to care, data exchange and support and other priority areas; and 2) Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to take actions necessary to implement the proposed initiatives, subject to staff first returning to the Board for approval of: a.) Additional initiative(s) related to member access and engagement; and b.) New and/or modified policies, and procedures, and contracts/contract amendments, as applicable. (Motion carried 2-0-0; Director Khatibi absent)***

INFORMATION ITEMS

9. Improving Transitions of Care for Members Experiencing Homelessness
David Ramirez, M.D., Chief Medical Officer, provided an overview of CalOptima's efforts on improving transitions of care for members experiencing homelessness.

As noted at the top of the agenda Information Item 10 was heard prior to the Consent Calendar.

The following reports were accepted as presented:
11. Quarterly Reports to the Quality Assurance Committee
   a. Quality Improvement Committee Report
   b. Program for All-Inclusive Care for the Elderly (PACE) Report
   c. Member Trend Report

COMMITTEE MEMBER COMMENTS
Committee members thanked staff for their work in preparing for the committee meeting.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 4:02 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: May 20, 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

February 20, 2020

CALL TO ORDER
Chair Lee Penrose called the meeting to order at 2:02 p.m. Director Schoeffel led the Pledge of Allegiance.

Members Present: Lee Penrose, Chair; Ria Berger; Scott Schoeffel

Members Absent: None

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Chief Financial Officer; Sharon Dwiers, Clerk of the Board

PUBLIC COMMENT
There were no requests for public comment.

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer, provided a final update on the dissolution of the CalOptima Foundation and noted the final tax return has been sent to the CalOptima Foundation Audit Committee for review and will be filed with IRS in March.

Ms. Huang also provided an update on the Department of Health Care Services (DHCS) Medi-Cal capitation rates. Current Medi-Cal capitation rates covers July 2019 to December 2020, which is an 18-month bridge period. Going forward, DHCS will set rates on a calendar year basis. Next year's Medi-Cal rates will be released during the 3rd or 4th quarters of 2020. This change will affect our next fiscal year's budget process. We will be using the existing rates for the first six months of FY 2020-21, which is July through December 2020. For the second half of the year, staff will calculate the rates based on internal projections since the draft rates will not be released until after the new fiscal year has begun.

INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period October 1, 2019 through December 31, 2019.

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The portfolio totaled $1.5 billion dollars at December 31, 2019. Of this amount, $900 million was in CalOptima's operating account and $567 million was included in CalOptima's Board-designated reserves.

Meketa Investment Group, Inc. completed an independent review of the investment reports prepared by CalOptima's three investment managers: MetLife, Payden & Rygel and Wells Capital. The review found that all investments were compliant with California Government Code section 53600 *et seq.*, and CalOptima's 2019 Annual Investment Policy.

Ms. Huang also provided an update on Phase 2 of Private Hospital Directed Payments (PHDP), noting that approximately $100 million will be released by DHCS by the end of March. CalOptima plans to make distributions to qualifying hospitals within 30 days after the funding is received.

CONSENT CALENDAR

3. Approve the Minutes of the November 15, 2019 Special Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the October 21, 2019 Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

REPORTS

4. Consider Recommending Board of Directors' Approval of Reappointment to the CalOptima Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Schoeffel, seconded and carried, the Finance and Audit Committee recommended the reappointment of Susan Munson to the Board of Directors' Investment Advisory Committee for a two-year term beginning March 5, 2020. (Motion carried 3-0-0)***

5. Consider Recommending Board of Directors Authorize Proposed Budget Allocation Change in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget for Translation Expenses
Belinda Abeyta, Executive Director, Operations, introduced this item.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommends that the Board of Directors' authorize reallocation of budgeted, but unused funds in the amount of $200,000 within Cultural & Linguistic Services from Printing and Postage to Translation Expense through June 30, 2020. (Motion carried 3-0-0)***

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6. Consider Recommending Board of Directors' Authorization of Expenditures in the CalOptima Fiscal Year 2019-20 Operating Budget for Claims Editing Solution and Recovery Services

Ms. Abeyta introduced the item and noted that the recommended action in the PowerPoint presentation should have read "in an amount not to exceed $1,395,000", instead of $1.4 million from existing reserves.

Action: ***On motion of Director Berger, seconded and carried, the Committee Recommended that the Board of Directors' authorize unbudgeted operating expenditures within the Medi-Cal program Purchased Services expense category in an amount not to exceed $1,395,000 ~~$1.4 million~~ from existing reserves for the following: 1.) An increase of up to $645,000 to fund contingency fees for pre-payment claims editing solutions of professional services claims; 2.) An increase of up to $750,000 to fund contingency fees for overpayment recoveries related to inpatient Diagnosis Related Group (DRG) and outpatient Ambulatory Payment Classification (APC) paid claims and non-pursuit fees. (Motion carried 3-0-0)*** Rev. 2/20/20

7. Consider Recommending Board of Directors' Allocation of Intergovernmental Transfer (IGT) 9 Funds

Candice Gomez, Executive Director, Program Implementation, provided an update on the allocation of IGT 9 Funds. It was noted that beginning with IGT 8 through 10 these funds are counted as part of the capitation revenue CalOptima receives from the DHCS, so any expenditure of these IGT funds that do not qualify as medical expenses become part of CalOptima's Administrative Loss Ratio (ALR). Ms. Gomez reviewed the four primary focus areas: Member Access and Engagement - $6.5 million; Quality Performance - $3.4 million; Data Exchange and Support - $2.0 million, and Other Identified Priority Areas - $33.1 million. Ms. Gomez also noted that the last focus area of Other Identified Priority Areas includes support for the Whole Child Model (WCM) Program, which is projected to generate an operating loss of $31.1 million for FY 2019-20.

Committee members expressed concern about the WCM program operating losses and questioned how these would be addressed in the absence of IGT funds prospectively.

CEO Michael Schrader shared that the other WCM plans are also losing money and most plans are funding operating losses from reserves. He also indicated that though the state will not adjust CalOptima's rates for FY 2019-20, it is anticipated that the state will address the rates prospectively.

After considerable discussion, the Committee took the following action:

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended Board of Directors' 1.) Approve the recommend allocation of IGT 9 funds in the amount of $45 million for initiatives for quality performance, access to care, data exchange and support and other priority areas; and 2.) Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to take actions necessary to implement the proposed initiative, subject to staff first returning to the Board for approval of; a.) Additional initiative(s) related to member access and engagement; and b.) New and/or***

modified policies and procedures, and contracts/contract amendments, as applicable. (Motion carried 3-0-0)

8. Consider Extension of Altruista Health Contract for Comprehensive Medical Management System

Mr. Schrader and Nora Onishi, Director, Information Services, introduced this item, noting that staff is recommending an extension for the contract rather than going out with a request for proposal (RFP) as CalOptima is currently going through an upgrade and hopes the upgrade will include the enhancements that staff has been requesting from Altruista.

After discussion on this item the Committee agreed to approve the action contingent on a successful upgrade.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended Board of Directors' authorize the Chief Executive Officer (CEO) to 1.) Extend the Altruista Contract through April 6, 2024, with the existing terms and conditions; and 2.) Authorize payment of maintenance and support fees to Altruista through the contract end-date at currently contracted rates, contingent on a successful upgrade. (Motion carried 3-0-0)***

Rev. 2/20/20

INFORMATION ITEMS

9. November and December 2019 Financials

Ms. Huang provided an overview of enrollment, operating performance, liquidity, Board-Designated Reserves, and CalOptima's tangible net equity (TNE) requirements as of November 30, 2019.

12. Proposed Change to Health Network Capitation Rate Structure

Ms. Huang provided an overview of the health network capitation rate structure, noting that staff is evaluating reimbursement levels for both fee-for-service and capitation. Ms. Huang reported that CalOptima has engaged Milliman for rebasing services and reported that this will be an opportunity to better align CalOptima's health network capitation rate categories to how CalOptima receives revenue.

13. Update on Business Insurance Renewal for Policy Year 2021

Kelly Klipfel, Director, Financial Compliance, provided an update on CalOptima's business insurance for Policy Year 2021. Ms. Klipfel noted that carriers are hesitant to issue quotes prior to approximately two months before the policy expiration date. Ms. Klipfel also reviewed the mandatory coverage and additional coverage categories as well as the process and timeline.

Ms. Huang responded to Chair Penrose's request for a primer on the upcoming budget process, noting that CalOptima staff is working with contracted actuaries at Milliman on health network capitation and on the rebasing. Ms. Huang noted that staff has been communicating with our health networks and hospitals to communicate information they may need for their budgeting processes. Budget primers will be presented at the April and May Board meetings and then the full budget will be brought to May 21, 2020 Finance and Audit Committee (FAC) for consideration. Following review by the FAC, the FY 2020-21 budget will be presented in June to the full Board for approval.

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The following Information Items were accepted as presented:
10. CalOptima Information Security Update
11. The Future of CalOptima Core Administrative System
14. Update on the Department of Health Care Services and the Center for Medicare & Medicaid Services Recoupments
15. Quarterly Operating and Capital Budget Update
16. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Whole-Child Model Financial Report
    c. Reinsurance Report
    d. Health Network Financial Report
    e. Contingency Contract Report

COMMITTEE MEMBER COMMENTS

Committee members thanked staff for their work in preparing the committee materials.

ADJOURNMENT

Hearing no further business, Chair Penrose adjourned the meeting at 3:47 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: May 21, 2020

Back to Agenda

MINUTES

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

December 10, 2019

A Special Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee (WCM FAC) was held on December 10, 2019, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Byron called the meeting to order at 10:05 a.m.

ESTABLISH QUORUM

Members Present: Maura Byron, Chair; Cathleen Collins; Sandra Cortez-Schultz; Brenda Deeley; Kathleen Lear; Kristen Rogers; Malissa Watson;

Members Absent: None

Others Present: Belinda Abeyta, Executive Director, Operations; Albert Cardenas, Director, Customer Service: Cheryl Simmons, Staff to the Advisory Committees. Customer Service; Praveena Lal, Administrative Assistant, Customer Service

MINUTES

Approve the Minutes of the February 26, 2019 Special Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

Action: ***On motion of Member Rogers, seconded and carried, the WCM FAC Committee approved the minutes of the February 26, 2019 meeting. (Motion carried 7-0-0)***

PUBLIC COMMENT

No Public Comments

REPORTS

Consider Approval of FY 2019-2020 WCM FAC Meeting Schedule

Chair Byron presented the proposed FY 2019-2020 meeting schedule. The Committee discussed moving the proposed February 25, 2020 meeting to March 10, 2020 due to conflicts with members of the committee.

Action: ***On motion of Member Lear, seconded and carried, the Committee approved the FY 2019-2020 Meeting Schedule with modifications. (Motion carried 7-0-0)***

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Consider Recommendation of Whole-Child Model Family Advisory Candidates

Chair Byron summarized the recommendations of the WCM FAC Nominations Ad Hoc Subcommittee, which consisted of Chair Byron and Members Rogers and Cortez-Schultz. The ad hoc committee met on December 6, 2019 to review the applications received for an Authorized Family Member and a Consumer Advocate/Community Based Organization seats. The ad hoc committee reviewed three applicants: one for an Authorized Family Member Representative and two for a Consumer Advocate/Community Based Organization Representative.

The ad hoc subcommittee recommended the following candidates for two of the available seats: Monica Maier for an Authorized Family Member Representative and Jacqui Knudsen of Family Voices of California as a Consumer Advocate Representative.

Action: ***On motion of Member Lear, seconded and carried, the Committee approved the Recommended slate of WCM FAC Candidates. (Motion carried 7-0-0).***

INFORMATION ITEMS

Whole-Child Model Member Updates

Chair Byron reminded the members who still had outstanding compliance courses to complete them before December 31, 2019 to stay compliant and be able to continue to attend meetings.

ADJOURNMENT

Hearing no further business, Chair Byron adjourned the meeting at 12:35 p.m.

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

Approved: April 28, 2020

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MINUTES

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

February 25, 2020

A Special Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on February 25, 2020, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Tolbert called the meeting to order at 9:03 a.m. and Sally Molnar led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Christine Tolbert, Chair; Diana Cruz-Toro (9:08 am); Connie Gonzalez; Patty Mouton (9:13 am); Sally Molnar; Jaime Munoz (9:05 am); Ilia Rolon; Sr. Mary Therese Sweeney; Mallory Vega.

Members Absent: Pamela Pimentel, Sandra Finestone

Others Present: Michael Schrader, Chief Executive Officer Ladan Khamseh, Chief Operating Officer; Dr. David Ramirez, 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; Albert Cardenas, Director, Customer Service; Cheryl Simmons, Sr. Program Specialist, Staff to the Advisory Committees, Customer Service; Samantha Fontenot, Program Assistant, Customer Service.

At this time, Chair Tolbert rearranged the agenda to hear Public Comment and the CEO and Management reports while awaiting a quorum.

PUBLIC COMMENT
No public comment.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer (CEO) Update
Michael Schrader, Chief Executive Officer, provided a verbal update to the committee on how CalOptima's Program of All-Inclusive Care to the Elderly (PACE) has been recognized for increasing access to services by the National PACE Association. He also noted that CalOptima's PACE Program has also achieved "Supernova" and "Shooting Stars" distinctions for growing over 90% in the fourth quarter of 2019.

Chief Operating Officer (COO) Update
Ladan Khamseh, Chief Operating Officer, provided a verbal update on the Qualified Medicare Beneficiary (QMB) Program outreach to the members. She noted that CalOptima has received approximately 450 forms out of the 650 forms that were mailed out to members. Ms. Khamseh also

mentioned CalOptima's new Behavioral Health internal transition and its benefits for the OneCare and OneCare Connect members, which launched on January 1, 2020.

Chief Medical Officer (CMO) Update

Dr. David Ramirez, CMO, provided a verbal update on CalOptima's initiatives to improve member access to care. He also discussed the new incentives for providers to host afterhours access for evenings and weekends for all CalOptima members. He also mentioned CalOptima's initiatives regarding Telehealth which is a part of the Intergovernmental Transfer 9 (IGT) Fund.

Upon achieving a quorum, Chair Tolbert asked to return to agenda items III and V.

MINUTES

Approve the Minutes of the August 8, 2019 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Member Sally Molnar, seconded and carried, the MAC approved the minutes as submitted. (Motion carried 9-0-0; Members Pimentel and Finestone absent)***

Approve the Minutes of the October 10, 2019 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and the Whole-Child Model Family Advisory Committee

Action: ***On motion of Member Sr. Mary Therese Sweeney, seconded and carried, the MAC approved the minutes as submitted. (Motion carried 9-0-0; Members Pimentel and Finestone absent)***

REPORTS

Consider Recommendation to Rename Member Advisory Committee Seats

The Joint Advisory Recruitment Ad Hoc Committee recommended that the Member Advisory Committee rename the Persons with Mental Illness seat to Mental/Behavioral Health Representative and rename the Medically Indigent Persons seat to Medical Safety Net Representative.

Action: ***On motion of Member Mallory Vega, seconded and carried, the MAC approved the recommendation to rename the MAC Committee seats. (Motion carried 9-0-0; Members Pimentel and Finestone absent)***

Consider Recommendation to Revise Member Advisory Committee Chair and Vice Chair Term Lengths

The Joint Advisory Recruitment Ad Hoc Committee also recommended that the Chair and Vice Chair term lengths be changed from a one-year term to a two-year term to be aligned with all committees.

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Action: ***On motion of Member Patty Mouton, seconded and carried, the Committee approved the recommendation to extend the MAC Chair and Vice Chair Term Lengths. (Motion carried 9-0-0; Members Pimentel and Finestone absent)***

Consider Recommendation of Member Advisory Committee Candidate for Persons with Disabilities Representative

The Joint Ad Hoc Committee met to review the applications received for the open Persons with Disabilities Representative seat. The ad hoc reviewed and scored two applicants for the Persons with Disabilities Representative seat, Hai Hoang and Lucille Kowalski.

Action: ***On motion of Member Jaime Munoz, seconded and carried, the MAC approved the Recommendation of the Member Advisory Committee Candidate for Persons with Disabilities Representative. (Motion carried 9-0-0; Members Pimentel and Finestone absent)***

INFORMATION ITEMS

MAC Member Updates

Chair Tolbert noted that recruitment has an opened for the following seats whose terms are expiring on June 30, 2020. They are as follows; Children, Consumer, Foster Children, Long-Term Services and Supports, Medically Indigent Persons, Persons with Mental Illness, and Persons with Special Needs. Mrs. Tolbert also mentioned that the Health Care Agency seat is open and CalOptima staff is working on appointing someone for that seat. The recruitment will run from March 1 – March 31, 2020. She noted that the candidate recommendations will be presented at the May or June Board meeting. Member Ilia Rolon, noted that the First 5 Commission is actively recruiting for their Board of Directors.

Trauma Informed Care and Proposition 56 (Tobacco Tax) ACE Screening Presentation

Betsy Ha, Executive Director, Quality and Population Health Management, gave a presentation on a Trauma-Informed Care and Adverse Childhood Experiences (ACE) Screening. Ms. Ha discussed the impact of trauma on heath, evidence-based studies of ACEs and the impact to population heath and trauma informed care.

Health Homes Update

Tracy Hitzeman, Executive Director, Clinical Operations, provided an update on the Health Homes Program (HHP), which went live on January 1, 2020. Ms. Hitzeman mentioned that 3,000 CalOptima members are eligible for the first phase of this program, including those meeting criteria who are homeless. Ms. Hitzeman noted that outreach began via robo-call in January and approximately 1247 individuals were reached, with 34 members opting into the program.

Intergovernmental Transfer (IGT) 9 Presentation

Debra Kegel, Director, Strategic Planning, provided a presentation on the Intergovernmental Transfer (IGT) 9 funds that CalOptima is expecting. Ms. Kegel noted that CalOptima will receive approximately $45 million which will be available to be used for Medi-Cal services and that

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beginning with IGT 8, the Department of Health Care Services (DHCS) views IGT funding as part of the capitation CalOptima receives in exchange for providing medically necessary, covered services for Medi-Cal beneficiaries. She also noted that four focus areas had been identified for use of these funds, including member access and engagement, quality performance programs, data exchange and support, and other identified priority areas.

Medi-Cal Healthier California for All Presentation

Pallavi Patel, Director, Process Excellence, presented on the CalAIM program that has been renamed Medi-Cal Healthier California for All. Ms. Patel provided an overview of the goals for this program as well as the DHCS timeline for this new program, which will be implemented statewide in stages concluding with full integration by January 1, 2026. Ms. Patel also mentioned that CalOptima is required to submit a transition plan by July 2020 that addresses how the Whole-Person Care (WPC) and HHP will move to enhance care management and in lieu of services, effective January 2021.

Behavioral Health Update

Edwin Poon, Ph.D., Director, Behavioral Health Services presented on CalOptima's Behavioral Health program and noted that at its May 9, 2019 meeting, the CalOptima Board of Directors approved transitioning the OneCare and OneCare Connect behavioral health services from Magellan to CalOptima. This transition became effective on January 1, 2020 for members with mild to moderate mental health conditions. Dr. Poon also reviewed the behavioral health benefits that are managed by CalOptima and noted an internal department restructuring had been completed to enhance the management of behavioral health for all CalOptima lines of business.

ADJOURNMENT

Chair Tolbert announced that the next MAC meeting is scheduled for Thursday, April 9, 2020 at 2:30 p.m. Hearing no further business, she adjourned the meeting at 11:02 a.m.

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

Approved: May 14, 2020

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MINUTES

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

March 12, 2020

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, March 12, 2020, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

John Nishimoto, O.D., PAC Chair, called the meeting to order at 8:05 a.m. Member Dr. Sweidan led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Anjan Batra, M.D.; Tina Bloomer, MHNP; Andrew Inglis, M.D.; Jena Jensen (8:07 a.m.); Craig Myers; Pat Patton, MSN; Jacob Sweidan, M.D.; Loc Tran, PharmD.
Members Absent:	Donald Bruhns; John Kelly, M.D.; Junie Lazo-Pearson
Others Present:	Michael Schrader, 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; Candice Gomez, Executive Director, Program Implementation; Betsy Ha, Executive Director, Quality and Population Health Management; Tracy Hitzeman, Executive Director, Clinical Operations; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Assistant.

MINUTES

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

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the February 13, 2020 regular meeting. (Motion carried 9-0-0; Members Batra, Bruhns, Kelly and Lazo Pearson absent.)***

PUBLIC COMMENTS

There were no public comments.

Chair Nishimoto welcomed Andrew Inglis, M.D. as the new Orange County Health Care Agency Representative on the PAC.

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REPORTS

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer (CEO), discussed the All Plan CEO meeting at the Department of Health Care Services (DHCS) and noted that they covered essential items including the Coronavirus (COVID-19). Mr. Schrader also noted that a main topic of concern at the All Plan meeting was the increase in lead levels in children.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, provided an update on Qualified Medicare Beneficiary (QMB) Program outreach to qualified CalOptima Members and noted that 99% of the application forms had been returned by eligible members.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, announced that Miles Masatsugu, M.D., Medical Director would be leading the internal CalOptima clinical team in response to the COVID-19. He also noted that CalOptima's Pharmacy department began allowing early refills of maintenance medications on February 28, 2020.

Chief Financial Officer Update

Nancy Huang, Chief Financial Officer presented a quarterly financial update to the PAC and also explained the on-going budget process which will be submitted for approval at the June 4, 2020 Board meeting. Ms. Huang also shared that next year's DHCS rates will be shared via calendar year and not on a fiscal year basis as is currently done and that for this budget cycle the timeframe of July 1, 2020 through December 31, 2020, CalOptima must use a forecast method to establish a budget which elicited much discussion among the members.

INFORMATION ITEMS

Coronavirus (COVID-19) Update

Miles Masatsugu, M.D., Medical Director presented on the COVID-19 pandemic. He updated the members on CalOptima's COVID-19 response to date and noted CalOptima continues to monitor and follow county and state public health guidance. CalOptima continues recommending preventive measures for members and staff by washing hands frequently, using disinfectant wipes, encouraging employees to stay home when sick. He also noted that CalOptima is preparing by reviewing emergency and infections disease policies and protocols for both CalOptima and the PACE Center. He noted that in addition to the pharmacy rules change, that CalOptima would continue to pay for emergency department and inpatient care and ensure that testing, vaccination and treatments are covered as they become available. He also noted that a Communications plan has been executed to reach all members and stakeholders by use of the CalOptima website member portal and social media. Regular updates will be sent weekly to providers and health networks.

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Chair Nishimoto rearranged the agenda to hear item VI.D Whole-Child Model Update and VI.E. Member Advisory Committee Update before continuing with the agenda.

Whole-Child Model Update
Tracy Hitzeman, Executive Director, Clinical Operations, provided an update on Whole-Child Model. She noted that CalOptima continues to work with the families to address continuity of care prior to June 30, 2020.

Member Advisory Committee Update
Christine Tolbert, Chair of the Member Advisory Committee (MAC) provided an update on MAC activities. MAC Chair Tolbert asked that the PAC keep the MAC apprised and involved in delivery system discussions. She also reiterated how important joint meetings were that involved agenda items that were of mutual interest to both committees.

Intergovernmental Transfer (IGT) 9 Update
Debra Kegel, Director, Strategic Development presented on the Intergovernmental Transfer (IGT) 9 funds. Ms. Kegel estimated that CalOptima will receive approximately $45 million which will be available to be used for Medi-Cal services. She noted that four focus areas had been identified for use of these funds, including member access and engagement, quality performance programs, data exchange and support, and other identified priority areas.

PAC Member Updates
Chair Nishimoto announced that the Board had approved the recommended changes to the PAC structure. The vacant Long-Term Services and Support seat has been made into an Allied Health Services seat and the Traditional/Safety Net seat has been renamed to Safety Net Representative. Recruitment began on March 1, 2020 and concludes on March 31, 2020 for these seats. Applications are available on the CalOptima website or interested individuals may contact Cheryl Simmons, Staff to the Advisory Committees. Chair Nishimoto also noted that nominations for the Chair and Vice Chair positions were also being accepted. Staff continues to recruit for the two Allied Health Services seat along with the current seats available which are: Community Health Centers, Hospital, Physician and Safety Net Representatives.

ADJOURNMENT
Hearing no further business, Chair Nishimoto adjourned the meeting at 10:00 a.m.

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

Approved: May 14, 2020

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MINUTES

SPECIAL JOINT MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' MEMBER ADVISORY COMMITTEE AND PROVIDER ADVISORY COMMITTEE

April 9, 2020

A Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC), and Provider Advisory Committee (PAC) was held on Thursday, April 9, 2020, via live Webinar originating at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Nishimoto called the meeting to order at 9:10 a.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Member Advisory Committee

Members Present: Christine Tolbert, Chair; Pamela Pimentel, Vice Chair; Diana Cruz-Toro; Sandy Finestone; Connie Gonzalez; Hai Hoang; Sally Molnar; Patty Mouton; Jamie Munoz; Sr. Mary Therese Sweeney.

Members Absent: Mallory Vega

Provider Advisory Committee

Members Present: John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Anja Batra, M.D.; Tina Bloomer, MHNP; Donald Bruhns; Andrew Inglis M.D.; Jena Jensen; John Kelly, M.D.; Junie Lazo-Pearson Ph.D.; Pat Patton, MSN, RN; Jacob Sweidan M.D.; Loc Tran, Pharm.D.

Members Absent: Craig Myers

Others Present: Michael Schrader, Chief Executive Officer; Richard Sanchez, Interim Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D. Chief Medical Officer; Gary Crockett, Chief Counsel; Silver Ho, Executive Director, Compliance; Belinda Abeyta, Executive Director, Operations; Candice Gomez, Executive Director, Program Implementation; Tracy Hitzeman, Executive Director Clinical Operations; Michelle Laughlin, Executive Director, Network Operations; Betsy Ha, Executive Director, Quality & Population Health Management; TC Roady, Director, Regulatory Affairs and Compliance; Albert Cardenas, Director, Customer Service; Cheryl Simmons, Staff to the Advisory Committees, Customer Service; Kathi Porcho, Administrative Assistant, Provider Relations; Samantha Fontenot, Program Assistant, Customer Service

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PUBLIC COMMENT

Chair Tolbert announced there were no requests for public comment.

At this time, Chair Tolbert welcomed Hai Hoang to the MAC. Mr. Hoang was appointed by the CalOptima Board of Director's on April 2, 2020 as the Persons with Disabilities representative. Mr. Hoang is the Chief Operating Officer of the Illumination Institute.

CEO MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer (CEO), welcomed members of the Committees and introduced the new Interim Chief Executive Officer, Richard Sanchez. Mr. Sanchez provided a CEO update and mentioned that the Federal and State Legislative update would be returning to the committees. He also reviewed upcoming legislative items with the Committees.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer (COO), welcomed Hai Hoang to the MAC. Ms. Khamseh provided an update on the Qualified Medicare Beneficiaries (QMB) outreach to CalOptima members and she noted the application period for 2020 had ended in the March. She also noted that CalOptima members who qualified for Medicare Part A would receive benefits starting in July 2020. Ms. Khamseh also mentioned that CalOptima has updated their Customer Service phone messages and the Member Portal with COVID-19 information.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, welcomed Interim Chief Executive Officer Richard Sanchez and gave a brief update on the Health Homes Program, and as of April 1, 2020 there are over 265 CalOptima members enrolled in this program. He noted that phase two of the Health Homes Program will become effective July 1, 2020. Dr. Ramirez mentioned the Department of Health Care Services (DHCS) pharmacy carve out remains scheduled for January 1, 2021. Dr. Ramirez also mentioned that the DHCS Behavioral Health Incentive Program implementation has been deferred to July 1, 2020.

INFORMATION ITEMS

Coronavirus (COVID-19) Update

David Ramirez, M.D., Chief Medical Officer, provided an up-to-date presentation on the Coronavirus (COVID-19) to both committees. The presentation highlighted CalOptima's response to COVID-19. Dr. Ramirez discussed telehealth, testing and treatment, surge capacity, and CalOptima's COVID-19 communication methods with members, the public, and with CalOptima staff.

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Optometry Scope of Practice Presentation

Dr. Nishimoto provided an informative presentation on the expansion of the scope of practice for Optometry. Dr. Nishimoto discussed AB- 443 legislative bill which became effective January 2018 and expands the number of procedures optometrists may offer to patients. He noted that this bill authorizes an optometrist certified to use therapeutic pharmaceutical agents to diagnose and treat specified conditions and perform certain procedures.

Provider Advisory Committee Update

PAC Chair Dr. Nishimoto also provided a requested PAC initiative update to the MAC members since both committees are interested in doing more collaborative work.

Committee Member Updates MAC and PAC

MAC Chair Tolbert notified both the MAC and PAC that recruitment has been extended through April 30, 2020. Chair Tolbert also told the MAC members that there would be a Special MAC meeting on May 14, 2020.

Committee Member Comments

The MAC and PAC members extended their individual well wishes to Michael Schrader and welcomed Richard Sanchez to CalOptima.

ADJOURNMENT

There being no further business before the Committees, Chair Nishimoto adjourned the meeting at 11:12 a.m.

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

Approved by Member Advisory Committee: May 14, 2020

Approved by Provider Advisory Committee: May 14, 2020

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Ratification of Expenditures Related to Emergency Repairs for CalOptima Facilities

Contact

Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Action

Ratify unbudgeted expenditures from existing reserves for emergency repairs at CalOptima facilities located at 505 City Parkway West in Orange (505 Building) in the amount of $19,877.55

Background

CalOptima owns a 10-story commercial office building located at 505 City Parkway West in Orange, with all floors occupied by CalOptima staff. CalOptima is responsible to ensure that the facilities are secure, clean and fully operational in order to safely accommodate the needs of employees, members, and other visitors.

Discussion

Staff recommends that the Board ratify unbudgeted expenditures for emergency repairs to the 505 Building. Upon inspection of the logo signs located on the 505 Building on February 4, 2020, staff found that the trim caps and screws were failing, falling off or breaking in some spots, representing a potential safety issue. The screws and caps required replacement on the signs on both elevations of the 505 Building. Without prompt replacement, the signs, due to their weight, could fall to the ground and cause serious personal injury or property damage. On March 24, 2020, to avoid potential property damage and endangering others, staff utilized a bid exception, staff made an emergency purchase of $19,877.55 through CalOptima's currently contracted vendor to repair the sign. CalOptima contracted with the same vendor to ensure continuity of service, compatibility with existing equipment, and the protection and security of CalOptima's building, its employees, members and guests.

The emergency purchases with the contracted vendor were completed with an emergency bidding exception in accordance with section II.P. of CalOptima Policy GA.5002: Purchasing Policy.

Fiscal Impact

The recommended action to authorize ratification of expenditures for emergency repairs at the 505 Building are unbudgeted items. An allocation of up to $19,877.55 from existing reserves will fund this action.

Rationale for Recommendation

Staff recommends approval of the recommended action in furtherance of efforts to protect the CalOptima's property and assets and to avoid potential loss in the event life or property is endangered due to the conditions of the signs. Authorization of the expenditures will allow CalOptima to provide a secure and professional work environment for our employees and a safe environment for our members and guests.

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

Attachment
1. Contracted Entities Covered by this Recommended Board Action

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sign Specialist Corporation	111 West Dyer Road, Unit F	Santa Ana	CA	92707

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

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

Contact
Nancy Huang, Chief Financial Officer, (714) 246-8400

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

Background
At the February 27, 1996, meeting, the CalOptima Board of Directors (Board) approved the 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. Staff noted they received a recommended change for a 5% portfolio maximum limitation per credit counterparty and by instrument type to clarify the requirement in the current AIP. This change would be considered for possible adoption in a future policy update after further vetting by CalOptima's investment managers and committee members.

Discussion
CalOptima Policy GA.3400: Annual Investment gives investment guidelines for all Operating Funds and Board-Designated Reserve Funds invested on or after January 10, 2006. These guidelines 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.

Staff proposes to revise this policy to clarify counterparty diversification limits. This policy change noted in the December 5, 2019, Board action was discussed with CalOptima's investment advisor, Meketa Investment Group, Inc., in December 2019. Staff recommends revising the policy for 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. The proposed effective date for the policy change is July 1, 2020.

At its April 21, 2020, meeting, the IAC recommended that the Finance and Audit Committee recommend Board approval of the proposed revisions to CalOptima Policy GA.3400: Annual Investments.

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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 CalOptima's investment adviser, Meketa Investment Group, Inc. The recommended changes will 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.

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

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

/s/ Richard Sanchez *05/27/2020*
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:	TBD

Applicable to:
- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☒ Administrative

For 20200604 BOD Review Only

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.

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

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

    a. The performance Benchmark for each Investment Portfolio shall be based upon published Market Indices 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

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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.

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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;

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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);

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

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

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

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

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

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

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or equivalent or better for short-term obligations, or 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~~Banker's Acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances:

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

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

ii. Maximum Term:

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

e. Commercial Paper (CP)

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

a) CP of "prime" quality of the highest ranking or of the highest letter and number rating as provided for 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

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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.

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ii. Maximum Term:

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

iii. Reverse Repurchase Agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible Corporate Securities shall be rated 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).

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

ii. Maximum Term:

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

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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

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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);

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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)

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INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
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 ⩽ 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 ~~applies to all such securities backed by the same type of assets of the same issuer~~issuer limits apply at the deal level.

   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.

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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)

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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
	Regular Meeting of the CalOptima Investment Advisory Committee
	Regular Meeting of the CalOptima Finance and Audit Committee
	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	TBD	GA.3400	Annual Investments	Administrative

For 20200604 BOD Review Only

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.

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Term	Definition
Broker-Dealer	In financial services, a Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.
CalOptima Treasurer	Appointed by CalOptima's Board of Directors, the treasurer is a person responsible for overseeing CalOptima's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
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.

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Term	Definition
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..
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)

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Term	Definition
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any Capital gains realized on the sale of the investment.
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or Bonds of any of the fifty (50) U.S. states, including Bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
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:	TBD

Applicable to:
- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☒ Administrative

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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.

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

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

   a. The performance Benchmark for each Investment Portfolio shall be based upon published Market Indices 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

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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.

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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;

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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);

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

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

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

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

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

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

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or equivalent or better for short-term obligations, or 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.

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ii. Maximum Term:

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

e. Commercial Paper (CP)

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

a) CP of "prime" quality of the highest ranking or of the highest letter and number rating as provided for 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

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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.

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ii. Maximum Term:

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

iii. Reverse Repurchase Agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible Corporate Securities shall be rated 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:

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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

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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

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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)

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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.

   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.

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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

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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
	Regular Meeting of the CalOptima Investment Advisory Committee
	Regular Meeting of the CalOptima Finance and Audit Committee
	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	TBD	GA.3400	Annual Investments	Administrative

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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.

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Term	Definition
Broker-Dealer	In financial services, a Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.
CalOptima Treasurer	Appointed by CalOptima's Board of Directors, the treasurer is a person responsible for overseeing CalOptima's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
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.

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Term	Definition
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.
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)

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Term	Definition
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any Capital gains realized on the sale of the investment.
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or Bonds of any of the fifty (50) U.S. states, including Bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
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 June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Approval of Proposed Revisions to CalOptima Finance Policies

Contact

Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

Approve proposed revisions to the following Finance policies:

1. CalOptima Policy FF.1006: Financial Risk Arrangement;
2. CalOptima Policy FF.1009: Health-based Risk Adjusted Capitation Payment System;
3. CalOptima Policy FF.3002: Financial Oversight; and
4. CalOptima Policy FF.1010: Shared Risk Pool.

Background

CalOptima establishes new or 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.

Discussion

Staff recommends revisions to the following CalOptima policies:

- *CalOptima Policy FF.1006: Financial Risk Arrangement*. This policy describes the process by which CalOptima ensures that financial risk arrangements in Hospital Risk Pool Arrangements and Other Risk Arrangements are fair, equitable and appropriate for members assigned to a Physician-Hospital Consortium (PHC) health network. CalOptima staff recommends revisions to this policy pursuant to the CalOptima annual review process to ensure alignment with current operations and regulatory requirements. In the proposed update, CalOptima staff clarified the risk settlement submission deadline, as well as when the risk pool arrangements are required to be submitted for review.

- *CalOptima Policy FF.1009: Health-based Risk Adjusted Capitation Payment System*. This policy outlines the process by which CalOptima adjusts capitation payments to a health network based on the health status of the member population assigned to that health network. CalOptima staff recommends revisions to this policy pursuant to the CalOptima annual review process to ensure alignment with current operations and regulatory requirements. CalOptima staff recommends incorporating clarifying language regarding member risk scores and health network risk factors, adding Affordable Care Act Expansion as a covered Aid Category effective July 1, 2020, and updating months of services used in calculations.

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- *CalOptima Policy FF.3002: Financial Oversight*. This policy outlines the process by which CalOptima monitors a health network's financial position and financial security reserves to ensure contract compliance and financial integrity. CalOptima staff recommends revising this policy pursuant to the CalOptima annual review process to incorporate relevant definitions and ensure alignment with current operations and regulatory requirements. CalOptima staff added recommends adding language clarifying that the fixed deposit of $50,000 applies to all lines of business.

- *CalOptima Policy FF.1010: Shared Risk Pool*. This policy outlines the process for CalOptima's administration of the shared risk pool with a shared risk group (SRG). CalOptima staff revised this policy pursuant to the CalOptima annual review process to ensure alignment with current operations and regulatory requirements. CalOptima staff incorporated clarifying language regarding the management and reporting of money related to shared risk. CalOptima Finance staff coordinated with CalOptima Contracting staff to ensure SRG contracts are updated concurrently to reflect the changes in this policy. Staff also intends to seek authority from the Board in June to amend CalOptima's Medi-Cal shared risk group contracts to be consistent with these proposed policy changes.

  During Calendar Year 2020, CalOptima staff plans to re-evaluate the financial security reserves and capitation withholds processes for each line of business and health network contract type and will return to the Board with further recommendations in the future.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended action is intended to keep CalOptima Finance policies in alignment with regulatory guidance and operational practices.

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

Attachments
1. CalOptima Policy FF.1006: Financial Risk Arrangement (redlined and clean)
2. CalOptima Policy FF.1009: Health-based Risk Adjusted Capitation Payment System (redlined and clean)
3. CalOptima Policy FF.3002: Financial Oversight (redlined and clean)
4. CalOptima Policy FF.1010: Shared Risk Pool (redlined and clean)

/s/ Richard Sanchez — *05/27/2020*
Authorized Signature — **Date**

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Policy ~~#~~:	FF.1006
Title:	**Financial Risk Arrangement**
Department:	Finance
Section:	Not Applicable
CEO Approval:	~~Michael Schrader~~
Effective Date:	09/01/02
~~Last Review Date:~~	~~07/01/18~~
~~Last~~ Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

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I. PURPOSE

This policy describes the process by which CalOptima ensures that financial risk arrangements set forth in **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** are fair, equitable, and appropriately reward **Providers** for cost-effective, high quality services to **Members** assigned to a **Physician Hospital Consortium (PHC).**

II. POLICY

A. **Hospital Risk Pool Arrangements**

1. If CalOptima requires a **PHC** to establish a **Hospital Risk Pool Arrangement**, the **PHC** shall do so pursuant to the terms and conditions of this Policy.

2. A **PHC** shall establish a hospital risk pool funded by hospital capitation dollars paid by CalOptima.

3. A **Primary Physician Group** shall be entitled to a minimum of fifty percent (50%) of any hospital risk pool surplus.

4. A **Primary Physician Group's** downside risk shall be limited to five percent (5%) of the **Primary Physician Group's** total **Capitation Payment**.

5. CalOptima shall ensure **PHC** compliance with **Hospital Risk Pool Arrangements** and may impose **Sanctions**, including **Capitation Payment** deductions, in accordance with CalOptima policies HH.2002Δ: **Sanctions** and HH.2005Δ: **Corrective Action Plan**.

B. All **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** developed by a **PHC** shall comply with the following:

1. A **PHC** shall design **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** primarily to create incentives for **Providers**;

2. A **PHC** shall facilitate a common understanding and high level of trust between the various parties of **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** and shall make such **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** as administratively simple as possible;

Terms in **bold** are included in the Glossary.

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3. A **PHC** shall ensure that **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** are compliant with federal and state law;

4. A **PHC** shall not structure **Hospital Risk Pool Arrangements** or **Other Risk Arrangements** to deny or limit access or jeopardize quality of care;

5. A **PHC** shall ensure that each contracting **Provider** has the administrative and financial capacity to meet its contractual obligations; and

6. A **PHC** shall have a mechanism to detect and correct under-service by an at-risk **Provider**, including possible underutilization of specialist services and preventive health care services.

C. A **PHC** shall ensure that **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** are agreed to by written contract and signed by all parties, and shall submit signed **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** to CalOptima ~~in accordance with Section III.C of this Policy~~and its Contracted Vendor upon initial set-up, following subsequent revisions, and upon request.

D. CalOptima or its Contracted Vendor shall review and provide comments, as necessary, on the appropriateness of a **PHC's Hospital Risk Pool Arrangements** and **Other Risk Arrangements** pursuant to the terms and conditions of this Policy.

III. PROCEDURE

A. A **PHC** shall document a **Hospital Risk Pool Arrangement** in a risk pool agreement. The risk pool agreement shall be agreed to, and signed by, both the **Primary Physician Group** and **Primary Hospital**, and shall delineate the following minimum provisions:

1. Risk pool funding sources (i.e., hospital **Capitation Payments**, reinsurance recoveries, coordination of benefit collections);

2. Services that are debited against the risk pool;

3. Valuation of services debited against the risk pool;

4. Surplus sharing;

5. Deficit sharing;

6. Calculation period and settlements; and

7. Dispute resolution.

B. Calculations and settlements related to **Hospital Risk Pool Arrangements**

1. A **PHC** shall perform risk pool settlement calculations on a quarterly basis, and shall obtain signatures from the **Primary Physician Group**, **Primary Hospital**, and any other participating entities on the calculations.

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2. A **PHC** shall provide copies of all quarterly or other interim settlement calculations to CalOptima or its Contracted Vendor as requested during any annual financial audits and/or reviews.

3. A **PHC** shall calculate ~~final~~annual settlements for a given contract year, acquire signatures from representatives of the ~~applicable parties~~participating entities, issue payment per the timeline defined in the Hospital Risk Pool Arrangement, and submit the ~~final~~annual settlements and proof of the payments to CalOptima or its Contracted Vendor ~~within one hundred eighty (180) calendar days following the end of the applicable contract year~~as part of the annual review of the **PHC's** Medical Loss Ratio calculation.

C. Written communication to a **Provider** regarding **Other Risk Arrangements**

1. A **PHC** shall provide clear, written communication to a **Provider** regarding **Other Risk Arrangements** and any risk pool settlements.

2. A **PHC** shall provide a **Provider** with a copy of the risk pool settlement calculation, and

   a. The calculation of the **Provider's** particular risk pool dollar share amount; or

   b. A written explanation as to why the **Provider** is not eligible for a distribution under the **Other Risk Arrangement**.

D. CalOptima's oversight of **Hospital Risk Pool Arrangements** and **Other Risk Arrangements**

1. CalOptima or its Contracted Vendor shall receive and review, upon request or as part of any financial audit and/or review, all settlement calculations and payment distributions to ensure that a **PHC** is compliant with the terms of the approved **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** and the provisions of this policy.

2. If a **PHC** is non-compliant with any of the provisions in Section II of this policy, CalOptima shall require a **PHC** to submit a **Corrective Action Plan (CAP)** as appropriate, in accordance with CalOptima Policy HH.2005Δ **Corrective Action Plan**. CalOptima may impose **Sanctions,** including **Capitation Payment** deductions, in accordance with CalOptima Policy HH.2002Δ: **Sanctions**~~.~~, if **PHC** continues to be non-compliant with any of the provisions in Section II of this policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Network Service Agreement
B. CalOptima Policy HH.2002Δ: Sanctions
C. CalOptima Policy HH.2005Δ: Corrective Action Plan
D. Title 28, California Code of Regulations (C.C.R.), §§1300.70(b)(2)(H)(1) and (2)
~~E. This policy supersedes:~~
~~a. CalOptima Financial Letter dated August 11, 1995: Financial issues update~~
~~b. CalOptima Financial Bulletin #1: Schedule and process of capitation payments~~

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c. CalOptima Financial Bulletin #2: Risk pool guidelines
d. CalOptima Financial Bulletin #9: CalOptima survey of physician compensation
e. CalOptima Financial Bulletin #11: Risk pool agreements and settlements
f. CalOptima Financial Bulletin #12: Financial arrangements with subcontractors
g. CalOptima Financial Bulletin #20: CalOptima hospital risk pool surplus withhold
a.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2002	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	03/01/2003	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	07/01/2007	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	01/01/2008	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	08/01/2010	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	09/01/2014	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	08/01/2016	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Reviewed	05/01/2017	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Revised	07/01/2018	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Revised	TBD	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect

For 20200604 BOD Review Only

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.
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.
Capitation Rate	The per capita rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age, and gender.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory or contractual obligations and other requirements identified by CalOptima and its regulators.
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), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Health Network	A Physician Hospital Consortium (PHC), ~~Physician Medical Group (PMG)~~physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Hospital Risk Pool Arrangements	A risk arrangement contractually required by CalOptima between a physician and hospital partner funded by hospital capitation dollars paid by CalOptima.
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.~~An enrollee-beneficiary of a CalOptima program.
Other Risk Arrangements	A risk arrangement between Health Network partner or Health Network participants outside of a Hospital Risk Pool Arrangement.

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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).
Program	Any of CalOptima's programs including the CalOptima Medi-Cal Program, OneCare, OneCare Connect, PACE, or the Multipurpose Senior Services Program.
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.
Sanction	An action taken by CalOptima including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

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Policy:	FF.1006
Title:	**Financial Risk Arrangement**
Department:	Finance
Section:	Not Applicable
CEO Approval:	
Effective Date:	09/01/02
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

For 20200604 BOD Review Only

I. PURPOSE

This policy describes the process by which CalOptima ensures that financial risk arrangements set forth in **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** are fair, equitable, and appropriately reward **Providers** for cost-effective, high quality services to **Members** assigned to a **Physician Hospital Consortium (PHC).**

II. POLICY

A. **Hospital Risk Pool Arrangements**

1. If CalOptima requires a **PHC** to establish a **Hospital Risk Pool Arrangement**, the **PHC** shall do so pursuant to the terms and conditions of this Policy.

2. A **PHC** shall establish a hospital risk pool funded by hospital capitation dollars paid by CalOptima.

3. A **Primary Physician Group** shall be entitled to a minimum of fifty percent (50%) of any hospital risk pool surplus.

4. A **Primary Physician Group's** downside risk shall be limited to five percent (5%) of the **Primary Physician Group's** total **Capitation Payment**.

5. CalOptima shall ensure **PHC** compliance with **Hospital Risk Pool Arrangements** and may impose **Sanctions**, including **Capitation Payment** deductions, in accordance with CalOptima policies HH.2002Δ: **Sanctions** and HH.2005Δ: **Corrective Action Plan**.

B. All **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** developed by a **PHC** shall comply with the following:

1. A **PHC** shall design **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** primarily to create incentives for **Providers**;

2. A **PHC** shall facilitate a common understanding and high level of trust between the various parties of **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** and shall make such **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** as administratively simple as possible;

Terms in **bold** are included in the Glossary.

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3. A **PHC** shall ensure that **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** are compliant with federal and state law;

4. A **PHC** shall not structure **Hospital Risk Pool Arrangements** or **Other Risk Arrangements** to deny or limit access or jeopardize quality of care;

5. A **PHC** shall ensure that each contracting **Provider** has the administrative and financial capacity to meet its contractual obligations; and

6. A **PHC** shall have a mechanism to detect and correct under-service by an at-risk **Provider**, including possible underutilization of specialist services and preventive health care services.

C. A **PHC** shall ensure that **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** are agreed to by written contract and signed by all parties, and shall submit signed **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** to CalOptima and its Contracted Vendor upon initial set-up, following subsequent revisions, and upon request.

D. CalOptima or its Contracted Vendor shall review and provide comments, as necessary, on the appropriateness of a **PHC's Hospital Risk Pool Arrangements** and **Other Risk Arrangements** pursuant to the terms and conditions of this Policy.

III. PROCEDURE

A. A **PHC** shall document a **Hospital Risk Pool Arrangement** in a risk pool agreement. The risk pool agreement shall be agreed to, and signed by, both the **Primary Physician Group** and **Primary Hospital**, and shall delineate the following minimum provisions:

1. Risk pool funding sources (i.e., hospital **Capitation Payments**, reinsurance recoveries, coordination of benefit collections);

2. Services that are debited against the risk pool;

3. Valuation of services debited against the risk pool;

4. Surplus sharing;

5. Deficit sharing;

6. Calculation period and settlements; and

7. Dispute resolution.

B. Calculations and settlements related to **Hospital Risk Pool Arrangements**

1. A **PHC** shall perform risk pool settlement calculations on a quarterly basis, and shall obtain signatures from the **Primary Physician Group**, **Primary Hospital**, and any other participating entities on the calculations.

2. A **PHC** shall provide copies of all quarterly or other interim settlement calculations to CalOptima or its Contracted Vendor as requested during any annual financial audits and/or reviews.

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3. A **PHC** shall calculate annual settlements for a given contract year, acquire signatures from representatives of the participating entities, issue payment per the timeline defined in the Hospital Risk Pool Arrangement, and submit the annual settlements and proof of the payments to CalOptima or its Contracted Vendor as part of the annual review of the **PHC's** Medical Loss Ratio calculation.

C. Written communication to a **Provider** regarding **Other Risk Arrangements**

1. A **PHC** shall provide clear, written communication to a **Provider** regarding **Other Risk Arrangements** and any risk pool settlements.

2. A **PHC** shall provide a **Provider** with a copy of the risk pool settlement calculation, and

   a. The calculation of the **Provider's** particular risk pool dollar share amount; or

   b. A written explanation as to why the **Provider** is not eligible for a distribution under the **Other Risk Arrangement**.

D. CalOptima's oversight of **Hospital Risk Pool Arrangements** and **Other Risk Arrangements**

1. CalOptima or its Contracted Vendor shall receive and review, upon request or as part of any financial audit and/or review, all settlement calculations and payment distributions to ensure that a **PHC** is compliant with the terms of the approved **Hospital Risk Pool Arrangements** and **Other Risk Arrangements** and the provisions of this policy.

2. If a **PHC** is non-compliant with any of the provisions in Section II of this policy, CalOptima shall require a **PHC** to submit a **Corrective Action Plan (CAP)** as appropriate, in accordance with CalOptima Policy HH.2005Δ **Corrective Action Plan**. CalOptima may impose **Sanctions,** including **Capitation Payment** deductions, in accordance with CalOptima Policy HH.2002Δ: **Sanctions**, if **PHC** continues to be non-compliant with any of the provisions in Section II of this policy**.**

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Network Service Agreement
B. CalOptima Policy HH.2002Δ: Sanctions
C. CalOptima Policy HH.2005Δ: Corrective Action Plan
D. Title 28, California Code of Regulations (C.C.R.), §§1300.70(b)(2)(H)(1) and (2)
   a.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

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VIII. REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2002	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	03/01/2003	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	07/01/2007	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	01/01/2008	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	08/01/2010	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	09/01/2014	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	08/01/2016	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Reviewed	05/01/2017	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Revised	07/01/2018	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Revised	TBD	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect

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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.
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.
Capitation Rate	The per capita rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age, and gender.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory or contractual obligations and other requirements identified by CalOptima and its regulators.
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), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Hospital Risk Pool Arrangements	A risk arrangement contractually required by CalOptima between a physician and hospital partner funded by hospital capitation dollars paid by CalOptima.
Member	An enrollee-beneficiary of a CalOptima program.
Other Risk Arrangements	A risk arrangement between Health Network partner or Health Network participants outside of a Hospital Risk Pool Arrangement.
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).

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Term	Definition
Program	Any of CalOptima's programs including the CalOptima Medi-Cal Program, OneCare, OneCare Connect, PACE, or the Multipurpose Senior Services Program.
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.
Sanction	An action taken by CalOptima including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

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Policy:	FF.1009
Title:	**Health-based Risk Adjusted Capitation Payment System**
Department:	Finance
Section:	Not Applicable
CEO Approval:	~~Michael Schrader~~
Effective Date:	07/01/2008
Revised Date:	~~10~~**07/01/**~~2019~~**2020**

I. PURPOSE

This policy outlines the process for CalOptima's Health-based Risk Adjusted (HRA) **Health Network Capitation Payment*** system.

II. POLICY

A. CalOptima shall adjust a **Health Network's Capitation Payment** to a Health-based Risk Adjusted (HRA) **Capitation Payment** based on the health status of the **Health Network's Member** population, in accordance with the terms and conditions of this Policy.

B. CalOptima shall utilize the **Chronic Illness and Disability Payment System (CDPS)** to adjust a **Health Network's Capitation Payment** to an HRA **Capitation Payment**.

C. ~~Effective on the **Department of Health Care Services (DHCS)** approved **Whole Child Model (WCM) program** implementation date, no sooner than July 1, 2019,~~ **Members** who are eligible for services under the **California Children's Services (CCS) Program** shall not qualify for risk adjustment under this Policy.

D. CalOptima shall risk-adjust a payment for a **Member** who:

1. Has an Aged, Blind, Disabled, Affordable Care Act (ACA) Expansion (effective July 1, 2020), or Temporary Assistance for Needy Families (TANF) **Aid Code**;

2. Is enrolled in CalOptima for at least six (6) months during a twelve (12) month risk adjustment period as described in Section III.B. of this Policy; and

3. Is enrolled in a **Health Network** during the periods described in Section III.C. of this Policy.

E. CalOptima shall develop a **Risk Assignment Database** to contain medical and diagnostic data for **Members** eligible for risk-adjustment pursuant to Section II.C. of this policy. CalOptima shall utilize the data in the **Risk Assignment Database** to determine a **Member's** Risk Score in accordance with Section III.B. of this Policy.

F. CalOptima shall calculate a **Health Network's** risk factor every six (6) months.

G. CalOptima shall apply a **Health Network's** risk factor in determining the **Health Network's Capitation Payment** for the following six (6) month **Payment Period**.

III. PROCEDURE

A. **Risk Assignment Database**

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* Terms in **bold** are included in the Glossary.

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1. The **Risk Assignment Database** shall contain information including, but not limited to:

   a. **Member** identification number;

   b. **Aid Code**;

   c. Diagnosis ~~code~~codes; and

   d. Procedure codes.

2. CalOptima shall extract information for the **Risk Assignment Database** from the following service categories:

   a. Inpatient services;

   b. Outpatient services; and

   c. Physician services.

B. Calculation of **Member's Risk Score**

1. CalOptima or its contracted vendor shall utilize the **Risk Assignment Database** to assign ~~a~~ **Members** a Risk Score using **CDPS** ~~and a~~; each **Member's Risk Score** is then normalized using the **Member's** **Health Network's** capitation age and gender factors. A **Health Network's** capitation age and gender factors are adjustments that take into account a **Health Network's** membership's age and gender mix.

2. CalOptima or its contracted vendor shall calculate a **Member's Risk Score** every six (6) months, in April and October.

3. CalOptima or its contracted vendor shall calculate a **Member's Risk Score** based on **Encounter** and claims data submitted for dates of service over a twelve (12) month risk adjustment period.

   a. For the Risk Score calculated in April ("year 3"), CalOptima shall use **Encounter** data submitted from a **Health Network** by March 20 ("year 3") for dates of service ~~December~~October ("year 1") through ~~November~~September ("year 2").

   b. For the Risk Score calculated in October ("year 3"), CalOptima shall use **Encounter** data submitted from a **Health Network** by September 20 ("year 3") for dates of service ~~June~~April ("year 2") through ~~May~~March ("year 3").

4. If a **Member** is eligible with CalOptima for less than six (6) months during a risk adjustment period, CalOptima or its contracted vendor shall not calculate a Risk Score for that **Member**.

C. Calculation of **Health Network Risk Factor**

1. A **Health Network's** raw risk factor is the weighted average of all Risk Scores for **Members** assigned to that **Health Network** at a defined time, as identified in Section III.C.4. of this policy.

2. CalOptima or its contracted vendor shall apply actuarial methodologies to derive statistically significant risk factors for each **Health Network**.

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3. CalOptima or its contracted vendor shall calculate a **Health Network's** risk factor every six (6) months, in April and October.

4. CalOptima or its contracted vendor shall calculate the average Risk Score for **Members** assigned to that **Health Network**.

   a. For the risk factor calculated in April, CalOptima or its contracted vendor shall use a **Health Network's** assigned membership as of April.

   b. For the risk factor calculated in October, CalOptima or its contracted vendor shall use a **Health Network's** assigned membership as of October.

   c. CalOptima or its contracted vendor shall only use Risk Scores for **Members** who are eligible as of the months described in Subsections III.C.4.a and III.C.4.b of this Section, to calculate a **Health Networks'** risk factor.

5. CalOptima or its contracted vendor shall normalize the average risk factor for each **Health Network** based on eligible **Members** in accordance with Section III.C.4 of this Policy, to ensure that the aggregate total **Capitation Payments** to all **Health Networks** remains budget neutral to CalOptima.

6. CalOptima shall notify a **Health Network** of its risk factor on May 15th and November 15th of each year.

D. Calculation of HRA **Capitation Payment**

1. CalOptima shall multiply a **Health Network's** monthly base **Capitation Payment** ~~for eligible **Members** as set forth in Section III.C of this Policy,~~ by the **Health Network's** risk factor to determine the **Health Network's** HRA **Capitation Payment**.

2. CalOptima shall apply a **Health Network's** risk factor in determining the **Health Network's** HRA **Capitation Payment** for the following six (6) month **Payment Period** as follows:

   a. The risk factor calculated in April shall apply to **Capitation Payments** for July through December of the same year; and

   b. The risk factor calculated in October shall apply to **Capitation Payments** for January through June of the following year.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the California Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
D. CalOptima Policy FF.1001: Capitation Payments

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VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
09/30/2009	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	~~Meeting~~Meetings
06/03/2008	Regular Meeting of the CalOptima Board of Directors
05/05/2009	Regular Meeting of the CalOptima Board of Directors
06/04/2009	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	07/01/2008	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	07/01/2009	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	09/01/2014	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	06/01/2016	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	05/01/2017	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	10/04/2018	FF.1009	Health-based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	12/01/2018	FF.1009	Health-based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	10/01/2019	FF.1009	Health-based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	**07/01/2020**	FF.1009	Health-based Risk Adjusted Capitation Payment System	Medi-Cal

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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	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 CalOptima Policy DD.2006.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Chronic Illness and Disability Payment System (CDPS)	A diagnostic classification system that Medicaid programs utilize to make health-based capitated payments for Temporary Assistance to Needy Families (TANF) and disabled Medicaid beneficiaries.
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.
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 Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Network Risk Factor	The weighted average of all Member Risk Scores for Members assigned to that Health Network at a defined time, normalized across all Health Networks to ensure that the aggregate total Capitation Payments to all Health Networks is budget neutral to CalOptima.
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.
Member Risk Score	A measurement of a Member's health status according to a minimum of one (1) diagnostic code.
Payment Period	For the purpose of this policy, payment period refers to a set interval of time in which CalOptima provides payment to Health Networks for Covered Services furnished to Members.

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Term	Definition
Risk Assignment Database	A database that contains Members' diagnostic and medical information as reported on the facility and professional Encounter data submitted by a Health Network in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and claims data collected by CalOptima for CalOptima Direct and Shared Risk Groups.
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.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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Policy:	FF.1009
Title:	**Health-based Risk Adjusted Capitation Payment System**
Department:	Finance
Section:	Not Applicable
CEO Approval:	
Effective Date:	07/01/2008
Revised Date:	07/01/2020

I. PURPOSE

This policy outlines the process for CalOptima's Health-based Risk Adjusted (HRA) **Health Network Capitation Payment** system.

II. POLICY

A. CalOptima shall adjust a **Health Network's Capitation Payment** to a Health-based Risk Adjusted (HRA) **Capitation Payment** based on the health status of the **Health Network's Member** population, in accordance with the terms and conditions of this Policy.

B. CalOptima shall utilize the **Chronic Illness and Disability Payment System (CDPS)** to adjust a **Health Network's Capitation Payment** to an HRA **Capitation Payment**.

C. **Members** who are eligible for services under the **California Children's Services (CCS) Program** shall not qualify for risk adjustment under this Policy.

D. CalOptima shall risk-adjust a payment for a **Member** who:

1. Has an Aged, Blind, Disabled, Affordable Care Act (ACA) Expansion (effective July 1, 2020), or Temporary Assistance for Needy Families (TANF) **Aid Code**;

2. Is enrolled in CalOptima for at least six (6) months during a twelve (12) month risk adjustment period as described in Section III.B. of this Policy; and

3. Is enrolled in a **Health Network** during the periods described in Section III.C. of this Policy.

E. CalOptima shall develop a **Risk Assignment Database** to contain medical and diagnostic data for **Members** eligible for risk-adjustment pursuant to Section II.C. of this policy. CalOptima shall utilize the data in the **Risk Assignment Database** to determine a **Member's** Risk Score in accordance with Section III.B. of this Policy.

F. CalOptima shall calculate a **Health Network's** risk factor every six (6) months.

G. CalOptima shall apply a **Health Network's** risk factor in determining the **Health Network's Capitation Payment** for the following six (6) month **Payment Period**.

III. PROCEDURE

A. **Risk Assignment Database**

1. The **Risk Assignment Database** shall contain information including, but not limited to:

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***** Terms in **bold** are included in the Glossary.

a. **Member** identification number;

b. **Aid Code**;

c. Diagnosis codes; and

d. Procedure codes.

2. CalOptima shall extract information for the **Risk Assignment Database** from the following service categories:

a. Inpatient services;

b. Outpatient services; and

c. Physician services.

B. Calculation of **Member's Risk Score**

1. CalOptima or its contracted vendor shall utilize the **Risk Assignment Database** to assign **Members** a Risk Score using **CDPS**; each **Member's Risk Score** is then normalized using the **Member's Health Network's** capitation age and gender factors. A **Health Network's** capitation age and gender factors are adjustments that take into account a **Health Network's** membership's age and gender mix.

2. CalOptima or its contracted vendor shall calculate a **Member's Risk Score** every six (6) months, in April and October.

3. CalOptima or its contracted vendor shall calculate a **Member's Risk Score** based on **Encounter** and claims data submitted for dates of service over a twelve (12) month risk adjustment period.

a. For the Risk Score calculated in April ("year 3"), CalOptima shall use **Encounter** data submitted from a **Health Network** by March 20 ("year 3") for dates of service October ("year 1") through September ("year 2").

b. For the Risk Score calculated in October ("year 3"), CalOptima shall use **Encounter** data submitted from a **Health Network** by September 20 ("year 3") for dates of service April ("year 2") through March ("year 3").

4. If a **Member** is eligible with CalOptima for less than six (6) months during a risk adjustment period, CalOptima or its contracted vendor shall not calculate a Risk Score for that **Member**.

C. Calculation of **Health Network Risk Factor**

1. A **Health Network's** raw risk factor is the weighted average of all Risk Scores for **Members** assigned to that **Health Network** at a defined time, as identified in Section III.C.4. of this policy.

2. CalOptima or its contracted vendor shall apply actuarial methodologies to derive statistically significant risk factors for each **Health Network**.

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3. CalOptima or its contracted vendor shall calculate a **Health Network's** risk factor every six (6) months, in April and October.

4. CalOptima or its contracted vendor shall calculate the average Risk Score for **Members** assigned to that **Health Network**.

   a. For the risk factor calculated in April, CalOptima or its contracted vendor shall use a **Health Network's** assigned membership as of April.

   b. For the risk factor calculated in October, CalOptima or its contracted vendor shall use a **Health Network's** assigned membership as of October.

   c. CalOptima or its contracted vendor shall only use Risk Scores for **Members** who are eligible as of the months described in Subsections III.C.4.a and III.C.4.b of this Section, to calculate a **Health Networks'** risk factor.

5. CalOptima or its contracted vendor shall normalize the average risk factor for each **Health Network** based on eligible **Members** in accordance with Section III.C.4 of this Policy, to ensure that the aggregate total **Capitation Payments** to all **Health Networks** remains budget neutral to CalOptima.

6. CalOptima shall notify a **Health Network** of its risk factor on May 15th and November 15th of each year.

D. Calculation of HRA **Capitation Payment**

1. CalOptima shall multiply a **Health Network's** monthly base **Capitation Payment** by the **Health Network's** risk factor to determine the **Health Network's** HRA **Capitation Payment**.

2. CalOptima shall apply a **Health Network's** risk factor in determining the **Health Network's** HRA **Capitation Payment** for the following six (6) month **Payment Period** as follows:

   a. The risk factor calculated in April shall apply to **Capitation Payments** for July through December of the same year; and

   b. The risk factor calculated in October shall apply to **Capitation Payments** for January through June of the following year.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the California Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
D. CalOptima Policy FF.1001: Capitation Payments

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VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
09/30/2009	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meetings
06/03/2008	Regular Meeting of the CalOptima Board of Directors
05/05/2009	Regular Meeting of the CalOptima Board of Directors
06/04/2009	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	07/01/2008	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	07/01/2009	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	09/01/2014	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	06/01/2016	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	05/01/2017	FF.1009	Health Based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	10/04/2018	FF.1009	Health-based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	12/01/2018	FF.1009	Health-based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	10/01/2019	FF.1009	Health-based Risk Adjusted Capitation Payment System	Medi-Cal
Revised	07/01/2020	FF.1009	Health-based Risk Adjusted Capitation Payment System	Medi-Cal

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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	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 CalOptima Policy DD.2006.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Chronic Illness and Disability Payment System (CDPS)	A diagnostic classification system that Medicaid programs utilize to make health-based capitated payments for Temporary Assistance to Needy Families (TANF) and disabled Medicaid beneficiaries.
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.
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 Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Network Risk Factor	The weighted average of all Member Risk Scores for Members assigned to that Health Network at a defined time, normalized across all Health Networks to ensure that the aggregate total Capitation Payments to all Health Networks is budget neutral to CalOptima.
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.
Member Risk Score	A measurement of a Member's health status according to a minimum of one (1) diagnostic code.
Payment Period	For the purpose of this policy, payment period refers to a set interval of time in which CalOptima provides payment to Health Networks for Covered Services furnished to Members.

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Term	Definition
Risk Assignment Database	A database that contains Members' diagnostic and medical information as reported on the facility and professional Encounter data submitted by a Health Network in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and claims data collected by CalOptima for CalOptima Direct and Shared Risk Groups.
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.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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Policy:	FF.3002
Title:	**Financial Oversight**
Department:	Finance
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/2007
~~Last~~ Revised Date:	~~07/01/18~~TBD

Applicable to:
- ☒ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative - External

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I. PURPOSE

This policy outlines the process by which CalOptima monitors a Health Network's financial position and financial security reserves to ensure ~~Contract~~contract compliance and financial integrity.

II. POLICY

A. CalOptima shall conduct Health Network financial reviews and periodic Focused Reviews as it deems necessary. CalOptima shall monitor a Health Network's financial position to promote:

1. Access to quality care for Members enrolled in the Health Network;
2. Appropriate and timely payment to Providers that render Covered Services to Members enrolled in the Health Network;
3. Financial integrity of CalOptima and its contractors; and
4. Financially prudent utilization of ~~capitation~~Capitation revenues received from the State of California.

B. Pursuant to the Contract for Health Care Services, CalOptima shall ensure that a Health Network complies with Financial Solvency Reserve requirements.

1. Financial Security Reserves - ~~A~~Each entity contracted as a Primary Physician Group, Primary Hospital, ~~and~~or Shared Risk Group (SRG) shall ~~each~~ establish and maintain financial security reserves in the form of time certificates of deposit, irrevocable standby letters of credit, or surety bonds naming CalOptima as beneficiary, equal to fifty-thousand dollars ($50,000) plus a minimum of twenty-five percent (25%) of one (1) month's average Capitation Payment, typically computed at the end of each quarter. CalOptima may require a greater amount based upon its assessment of the operational readiness and financial condition of the Primary Physician Group, Primary Hospital, or SRG. If the entity meets the fifty thousand dollars ($50,000) element of the financial security reserve requirement for participation as a contract holder with CalOptima for OneCare or OneCare Connect Members, the entity shall be deemed

to have met the fifty-thousand dollars ($50,000) element of the financial security reserve requirement for Medi-Cal.

2. Capitation Payment Withhold - CalOptima shall withhold from ~~a~~each Health Maintenance Organization (HMO), Primary Physician Group, Primary Hospital, and ~~Shared Risk Group (~~SRG~~)~~ an amount equal to twenty-five percent (25%) of a monthly Capitation Payment, typically computed at the end of each quarter. CalOptima may adjust the Capitation Payment ~~should the current withheld amount fall below~~each quarter to reflect twenty-five percent (25%) of the current ~~month~~month's Capitation Payment. CalOptima may increase this withhold rate based upon its assessment of the operational readiness and financial condition of the HMO, Primary Physician Group, Primary Hospital, or SRG.

3. An HMO contracted on a capitated basis to provide Covered Services to Members shall retain at all times a valid Knox-Keene license issued by the California Department of Managed Health Care (DMHC). CalOptima shall waive financial security reserves required for an HMO should the HMO meet the statutory requirement and maintain required Tangible Net Equity (TNE) in accordance with Title 28, California Code of Regulations, Section 1300.76.

III. PROCEDURE

A. Health Network Reporting of Financial Information

1. A Health Network shall report financial information to CalOptima on a quarterly and annual basis in accordance with CalOptima Policy FF.3001: Financial Reporting.

2. A Health Network shall report immediately to CalOptima any event that materially alters the Health Network's financial situation or threatens its solvency, pursuant to Title 28, California Code of Regulations; Sections 1300.75.4 through 1300.75.4.8. In such instances, CalOptima may require monthly reporting until such time that the Health Network's solvency is no longer in question.

B. CalOptima Review of Financial Information

1. CalOptima shall review a Health Network's Financial Statements and other financial information on a quarterly and annual basis to evaluate the data, trend indicators for the Health Network, and compare similar indicators between Health Networks including:

   a. Current ratio (must be greater than 1.0);

   b. Cash to claims ratio (must be greater than 0.75);

   c. Tangible Net Equity (TNE) (must be positive);

   d. Operating cash and equivalents position;

   e. Medical claims liability;

   f. Incurred ~~but not reported~~But Not Reported (IBNR) claims;

   g. Debt to equity ratio;

   h. Excess of revenues over expenses;

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i. Medical Loss Ratio (MLR); and

j. Administrative cost percentage.

2. CalOptima shall ensure that an HMO and a Risk Bearing Organization (RBO) complies with the DMHC TNE and fiscal solvency requirements by:

a. Reviewing the HMO's Orange Blank filings;

b. Reviewing the HMO's and RBO's audited Financial Statements and other reports submitted quarterly and annually to DMHC; and

c. Making appropriate inquiries of the HMO's and RBO's key financial personnel during any review.

3. CalOptima shall ensure that a contracting Health Network is in compliance with CalOptima fiscal solvency requirements by determining if it has established and maintained Financial Solvency Reserves in accordance with the provisions in this policy.

C. CalOptima Monitoring of Financial Solvency Reserves

1. ~~A~~Each entity contracted as a Primary Physician Group, Primary Hospital, ~~and~~or SRG shall establish financial security reserves in the form of Financial Security Instruments, as described in Section II.B.1.

a. The Financial Security Instruments, in the form of time certificates of deposit, irrevocable standby letters of credit or surety bonds, shall designate CalOptima as the sole beneficiary for the duration of the Primary Physician Group, Primary Hospital, or SRG's participation in the CalOptima program. CalOptima shall access these funds only in the event such funds are needed to protect the interests of~~,~~ and ensure the continuation of Covered Services to~~,~~ Members, or for administrative costs directly attributed to a conservatorship, receivership, or liquidation.

b. The Financial Security Instruments shall require the signature of an authorized CalOptima Officer in order to withdraw or transfer funds.

c. CalOptima shall monitor the financial security reserves and review their adequacy quarterly.

d. In the event the monthly Capitation Payments to a Primary Physician Group, Primary Hospital, or SRG materially increase due to membership or rate increases, CalOptima shall inform the Primary Physician Group, Primary Hospital, or SRG in writing that an increase in financial security reserves is required.

e. CalOptima shall not grant an adjustment to the financial security reserves for decreased monthly Capitation Payments to the Primary Physician Group, Primary Hospital, or SRG unless the decrease is material and only upon receiving a formal written request from the Primary Physician Group, Primary Hospital, or SRG.

f. In the event a Primary Physician Group, Primary Hospital, or SRG requests a substitution of a Financial Security Instrument, they shall submit the new Financial Security Instrument to

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CalOptima. CalOptima shall not release the old Financial Security Instrument prior to the receipt of the new Financial Security Instrument.

g. Release of Financial Security Reserves upon Health Network Termination

i. CalOptima shall release a Financial Security Instrument no earlier than six (6) months following a Primary Physician Group, Primary Hospital, or SRG's termination in the CalOptima program unless the termination is the result of the Primary Physician Group, Primary Hospital, or SRG's insolvency, in which case CalOptima shall release a Financial Security Instrument no earlier than twelve (12) months following a Primary Physician Group, Primary Hospital, or SRG's termination in the CalOptima program. Release shall only occur after the Primary Physician Group, Primary Hospital, or SRG has met all operational requirements.

ii. CalOptima shall inform the Primary Physician Group, Primary Hospital or SRG, in writing, of the expected date CalOptima will release a Financial Security Instrument following the Health Network's termination in the CalOptima Medi-Cal program.

2. CalOptima shall establish a Capitation Payment withhold for a Health Network.

a. CalOptima shall monitor Capitation Payment withholds and review their adequacy quarterly as described in Section II.B.2.

b. In the event the monthly Capitation Payments to a Health Network materially increase due to membership or rate increases, CalOptima shall inform the Health Network in writing that an increase in ~~capitation~~Capitation withhold is required and shall deduct the additional withhold amount in a future Capitation Payment.

c. In the event the monthly Capitation Payments to a Health Network materially decrease due to membership or rate decreases, CalOptima shall release the Capitation Payment withhold surplus to the Health Network in a future Capitation Payment.

d. Release of the Capitation Payment Withhold upon Health Network Termination

i. CalOptima shall release a Capitation Payment withhold not earlier than nine (9) months after a Health Network's termination in the CalOptima program unless the termination is the result of the Health Network's insolvency, in which case CalOptima shall release a Capitation Payment withhold no earlier than twelve (12) months following Health Network's termination in the CalOptima program. Release shall only occur after the Health Network has met all operational requirements.

ii. CalOptima shall inform the Health Network in writing of the expected date CalOptima will release a Capitation Payment withhold following the Health Network's termination in the CalOptima program.

D. CalOptima Summary and Reporting of Findings

1. CalOptima shall prepare summaries of the following:

a. Financial ratios and other financial elements by Health Network, trended quarterly;

b. Financial security reserves; and

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c. Capitation Payment withhold amounts.

2. CalOptima shall utilize the summaries described in Section III.D.1 of this Policy to:

a. Monitor the financial position of a Health Network during the Health Network financial review process; and

b. Assess Health Network compliance on an ongoing basis.

3. CalOptima shall summarize and report the results of any financial review and Focused Review to the Health Network, the Audit and Oversight Committee, CalOptima executive management, and CalOptima Finance & Audit Committee (FAC), as needed.

E. Corrective Action and Sanctions

1. If a Health Network fails to comply or meet any of the standards or requirements outlined in this policy, CalOptima may take the following actions:

a. Require a Health Network to submit a Corrective Action Plan (CAP) as appropriate, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

b. Place the Health Network in a contractual cure for breach of contract, including the following:

i. CalOptima may seize any Capitation and/or monies owed and place the Health Network under financial supervision until breach is cured. Financial supervision to include:

a) Withholding of monthly Capitation; and

b) Managing and releasing withheld Capitation to the Health Network to fund administrative expenses, Primary Care Provider (PCP) Capitation Payments and/or claims payments (limited specifically to months/dates of service that such withheld Capitation was intended to be used for payment);

ii. CalOptima may review the Health Network's financial statements, bank statements, and/or other records to ensure payments are made.

2. CalOptima may impose Sanctions in accordance with CalOptima Policy HH.2002Δ: Sanctions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Contract for Health Care Services
C. CalOptima Policy FF.3001: Financial Reporting
D. CalOptima Policy HH.2005Δ: Corrective Action Plan
E. CalOptima Policy HH.2002Δ: Sanctions
F. This policy supersedes:

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1. CalOptima Financial Letter dated August 11, 1995: Financial issues update
2. CalOptima Financial Bulletin #1: Schedule and process of capitation payments
3. CalOptima Financial Bulletin #13: 1997-98 Contract Year financial requirements

G. Title 10, California Code of Regulations (C.C.R), § 1300.76
H. Title 22, California Code of Regulations (C.C.R), § 51301 *et seq.*
I. Title 28, California Code of Regulations (C.C.R), §§ 1300.75.4 through 1300.75.4.8

~~V.~~VI. REGULATORY AGENCY ~~APPROVALS~~APPROVAL(S)

~~A. 03/07/16: Department of Health Care Services~~

Date	Regulatory Agency
03/07/16	Department of Health Care Services

~~VI.~~VII. BOARD ~~ACTIONS~~ACTION(S)

None to Date

~~VII.~~VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	12/01/1998	FF.1101	Monitoring Contractor's Financial Position	Medi-Cal
Revised	06/01/2001	FF.1101	Monitoring Contractor's Financial Position	Medi-Cal
Revised	09/01/2005	FF.1101	Monitoring Contractor's Financial Position	Medi-Cal
Effective	06/01/2001	FF.1102	Monitoring Contractor's Financial Security Reserves	Medi-Cal
Effective	01/01/2007	FF.3002	Financial Oversight	Medi-Cal
Revised	01/01/2008	FF.3002	Financial Oversight	Medi-Cal
Revised	02/01/2016	FF.3002	Financial Oversight	Medi-Cal
Revised	03/01/2017	FF.3002	Financial Oversight	Medi-Cal
Revised	07/01/2018	FF.3002	Financial Oversight	Medi-Cal
Revised	TBD	FF.3002	Financial Oversight	Medi-Cal

For 20220604 BOD Review Only

~~VIII.~~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.
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.
Capitation Rate	The per capita rate set by CalOptima for the delivery of Covered Services to Members 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), a physician group under a shared risk contract, or HMO, and DHCS Medi-Cal Managed Care Division Policy Letters . .
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.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program~~,~~ (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301~~,~~), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with ~~Section 6840, which~~ section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), ~~which~~ and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not~~-~~withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Managed Health Care (DMHC)	The State Agency responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 as amended.

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Term	Definition
Financial Solvency Reserves	Funds comprised of security reserves and/or capitation withhold that are required for the duration of a Physician Hospital Consortium's (PHC)'s, Shared Risk Group's (SRG)'s, or Health Maintenance Organization's (HMO)'s participation in the CalOptima program. These funds are used to protect the interests of and ensure the continuation of health care services to the Members assigned to the PHC, SRG or HMO; they may also be used for administrative costs directly attributable to a conservatorship, receivership or liquidation.
Financial Statement	Financial reports including balance sheets, income statements, statements of cash flows, statements of equity, and accompanying footnotes prepared in accordance with generally accepted accounting principles.
Financial Security Instrument	Time certificate of deposit, irrevocable standby letter of credit, or surety bond naming CalOptima as the beneficiary.
Focused Review	An audit that specifically targets areas of potential deficiency.
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 Medical Group (PMG)~~physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Incurred But Not Reported (IBNR)	~~IBNR means "incurred but not reported," and refers to an~~An estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network.
Knox-Keene Health Care Services Plan Act of 1975 (Knox-Keene)	The law that regulates HMOs and is administrated by the Department of Managed Health Care (DMHC), commencing with Section 1340 of the California Health and Safety Code.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Members by the total revenue received from CalOptima. Health Network medical costs would include payments to physicians (i.e. capitation, fee-for-service, or salary), medical groups/ independent practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
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).
Provider	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services.

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Term	Definition
Risk Bearing Organization (RBO)	A professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, or another lawfully organized group of physicians that: 1. Delivers, furnishes, or otherwise arranges for or provides health care services; and 2. Does all the following: a. Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees; b. Receives compensation for those services on a capitated or fixed periodic payment basis; and c. Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation payment made by the plan to the risk bearing organization.
Sanction	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, CalOptima policy, or other requirements related to CalOptima programs.
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.
Tangible Net Equity (TNE)	Net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are not past due; long term prepayments of deferred charges, and non-returnable deposits.

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Policy:	FF.3002
Title:	**Financial Oversight**
Department:	Finance
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative - External

For 20200604 BOD Review Only

I. PURPOSE

This policy outlines the process by which CalOptima monitors a Health Network's financial position and financial security reserves to ensure contract compliance and financial integrity.

II. POLICY

A. CalOptima shall conduct Health Network financial reviews and periodic Focused Reviews as it deems necessary. CalOptima shall monitor a Health Network's financial position to promote:

1. Access to quality care for Members enrolled in the Health Network;
2. Appropriate and timely payment to Providers that render Covered Services to Members enrolled in the Health Network;
3. Financial integrity of CalOptima and its contractors; and
4. Financially prudent utilization of Capitation revenues received from the State of California.

B. Pursuant to the Contract for Health Care Services, CalOptima shall ensure that a Health Network complies with Financial Solvency Reserve requirements.

1. Financial Security Reserves - Each entity contracted as a Primary Physician Group, Primary Hospital, or Shared Risk Group (SRG) shall establish and maintain financial security reserves in the form of time certificates of deposit, irrevocable standby letters of credit, or surety bonds naming CalOptima as beneficiary, equal to fifty-thousand dollars ($50,000) plus a minimum of twenty-five percent (25%) of one (1) month's average Capitation Payment, typically computed at the end of each quarter. CalOptima may require a greater amount based upon its assessment of the operational readiness and financial condition of the Primary Physician Group, Primary Hospital, or SRG. If the entity meets the fifty thousand dollars ($50,000) element of the financial security reserve requirement for participation as a contract holder with CalOptima for OneCare or OneCare Connect Members, the entity shall be deemed to have met the fifty-thousand dollars ($50,000) element of the financial security reserve requirement for Medi-Cal.

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2. Capitation Payment Withhold - CalOptima shall withhold from each Health Maintenance Organization (HMO), Primary Physician Group, Primary Hospital, and SRG an amount equal to twenty-five percent (25%) of a monthly Capitation Payment, typically computed at the end of each quarter. CalOptima may adjust the Capitation Payment each quarter to reflect twenty-five percent (25%) of the current month's Capitation Payment. CalOptima may increase this withhold rate based upon its assessment of the operational readiness and financial condition of the HMO, Primary Physician Group, Primary Hospital, or SRG.

3. An HMO contracted on a capitated basis to provide Covered Services to Members shall retain at all times a valid Knox-Keene license issued by the California Department of Managed Health Care (DMHC). CalOptima shall waive financial security reserves required for an HMO should the HMO meet the statutory requirement and maintain required Tangible Net Equity (TNE) in accordance with Title 28, California Code of Regulations, Section 1300.76.

III. PROCEDURE

A. Health Network Reporting of Financial Information

1. A Health Network shall report financial information to CalOptima on a quarterly and annual basis in accordance with CalOptima Policy FF.3001: Financial Reporting.

2. A Health Network shall report immediately to CalOptima any event that materially alters the Health Network's financial situation or threatens its solvency, pursuant to Title 28, California Code of Regulations; Sections 1300.75.4 through 1300.75.4.8. In such instances, CalOptima may require monthly reporting until such time that the Health Network's solvency is no longer in question.

B. CalOptima Review of Financial Information

1. CalOptima shall review a Health Network's Financial Statements and other financial information on a quarterly and annual basis to evaluate the data, trend indicators for the Health Network, and compare similar indicators between Health Networks including:

   a. Current ratio (must be greater than 1.0);

   b. Cash to claims ratio (must be greater than 0.75);

   c. Tangible Net Equity (TNE) (must be positive);

   d. Operating cash and equivalents position;

   e. Medical claims liability;

   f. Incurred But Not Reported (IBNR) claims;

   g. Debt to equity ratio;

   h. Excess of revenues over expenses;

   i. Medical Loss Ratio (MLR); and

   j. Administrative cost percentage.

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2. CalOptima shall ensure that an HMO and a Risk Bearing Organization (RBO) complies with the DMHC TNE and fiscal solvency requirements by:

    a. Reviewing the HMO's Orange Blank filings;

    b. Reviewing the HMO's and RBO's audited Financial Statements and other reports submitted quarterly and annually to DMHC; and

    c. Making appropriate inquiries of the HMO's and RBO's key financial personnel during any review.

3. CalOptima shall ensure that a contracting Health Network is in compliance with CalOptima fiscal solvency requirements by determining if it has established and maintained Financial Solvency Reserves in accordance with the provisions in this policy.

C. CalOptima Monitoring of Financial Solvency Reserves

1. Each entity contracted as a Primary Physician Group, Primary Hospital, or SRG shall establish financial security reserves in the form of Financial Security Instruments, as described in Section II.B.1.

    a. The Financial Security Instruments, in the form of time certificates of deposit, irrevocable standby letters of credit or surety bonds, shall designate CalOptima as the sole beneficiary for the duration of the Primary Physician Group, Primary Hospital, or SRG's participation in the CalOptima program. CalOptima shall access these funds only in the event such funds are needed to protect the interests of and ensure the continuation of Covered Services to Members, or for administrative costs directly attributed to a conservatorship, receivership, or liquidation.

    b. The Financial Security Instruments shall require the signature of an authorized CalOptima Officer in order to withdraw or transfer funds.

    c. CalOptima shall monitor the financial security reserves and review their adequacy quarterly.

    d. In the event the monthly Capitation Payments to a Primary Physician Group, Primary Hospital, or SRG materially increase due to membership or rate increases, CalOptima shall inform the Primary Physician Group, Primary Hospital, or SRG in writing that an increase in financial security reserves is required.

    e. CalOptima shall not grant an adjustment to the financial security reserves for decreased monthly Capitation Payments to the Primary Physician Group, Primary Hospital, or SRG unless the decrease is material and only upon receiving a formal written request from the Primary Physician Group, Primary Hospital, or SRG.

    f. In the event a Primary Physician Group, Primary Hospital, or SRG requests a substitution of a Financial Security Instrument, they shall submit the new Financial Security Instrument to CalOptima. CalOptima shall not release the old Financial Security Instrument prior to the receipt of the new Financial Security Instrument.

    g. Release of Financial Security Reserves upon Health Network Termination

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i. CalOptima shall release a Financial Security Instrument no earlier than six (6) months following a Primary Physician Group, Primary Hospital, or SRG's termination in the CalOptima program unless the termination is the result of the Primary Physician Group, Primary Hospital, or SRG's insolvency, in which case CalOptima shall release a Financial Security Instrument no earlier than twelve (12) months following a Primary Physician Group, Primary Hospital, or SRG's termination in the CalOptima program. Release shall only occur after the Primary Physician Group, Primary Hospital, or SRG has met all operational requirements.

ii. CalOptima shall inform the Primary Physician Group, Primary Hospital or SRG, in writing, of the expected date CalOptima will release a Financial Security Instrument following the Health Network's termination in the CalOptima Medi-Cal program.

2. CalOptima shall establish a Capitation Payment withhold for a Health Network.

a. CalOptima shall monitor Capitation Payment withholds and review their adequacy quarterly as described in Section II.B.2.

b. In the event the monthly Capitation Payments to a Health Network materially increase due to membership or rate increases, CalOptima shall inform the Health Network in writing that an increase in Capitation withhold is required and shall deduct the additional withhold amount in a future Capitation Payment.

c. In the event the monthly Capitation Payments to a Health Network materially decrease due to membership or rate decreases, CalOptima shall release the Capitation Payment withhold surplus to the Health Network in a future Capitation Payment.

d. Release of the Capitation Payment Withhold upon Health Network Termination

i. CalOptima shall release a Capitation Payment withhold not earlier than nine (9) months after a Health Network's termination in the CalOptima program unless the termination is the result of the Health Network's insolvency, in which case CalOptima shall release a Capitation Payment withhold no earlier than twelve (12) months following Health Network's termination in the CalOptima program. Release shall only occur after the Health Network has met all operational requirements.

ii. CalOptima shall inform the Health Network in writing of the expected date CalOptima will release a Capitation Payment withhold following the Health Network's termination in the CalOptima program.

D. CalOptima Summary and Reporting of Findings

1. CalOptima shall prepare summaries of the following:

a. Financial ratios and other financial elements by Health Network, trended quarterly;

b. Financial security reserves; and

c. Capitation Payment withhold amounts.

2. CalOptima shall utilize the summaries described in Section III.D.1 of this Policy to:

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a. Monitor the financial position of a Health Network during the Health Network financial review process; and

b. Assess Health Network compliance on an ongoing basis.

3. CalOptima shall summarize and report the results of any financial review and Focused Review to the Health Network, the Audit and Oversight Committee, CalOptima executive management, and CalOptima Finance & Audit Committee (FAC), as needed.

E. Corrective Action and Sanctions

1. If a Health Network fails to comply or meet any of the standards or requirements outlined in this policy, CalOptima may take the following actions:

a. Require a Health Network to submit a Corrective Action Plan (CAP) as appropriate, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

b. Place the Health Network in a contractual cure for breach of contract, including the following:

i. CalOptima may seize any Capitation and/or monies owed and place the Health Network under financial supervision until breach is cured. Financial supervision to include:

a) Withholding of monthly Capitation; and

b) Managing and releasing withheld Capitation to the Health Network to fund administrative expenses, Primary Care Provider (PCP) Capitation Payments and/or claims payments (limited specifically to months/dates of service that such withheld Capitation was intended to be used for payment);

ii. CalOptima may review the Health Network's financial statements, bank statements, and/or other records to ensure payments are made.

2. CalOptima may impose Sanctions in accordance with CalOptima Policy HH.2002Δ: Sanctions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Contract for Health Care Services
C. CalOptima Policy FF.3001: Financial Reporting
D. CalOptima Policy HH.2005Δ: Corrective Action Plan
E. CalOptima Policy HH.2002Δ: Sanctions
F. This policy supersedes:
   1. CalOptima Financial Letter dated August 11, 1995: Financial issues update
   2. CalOptima Financial Bulletin #1: Schedule and process of capitation payments
   3. CalOptima Financial Bulletin #13: 1997-98 Contract Year financial requirements
G. Title 10, California Code of Regulations (C.C.R), § 1300.76
H. Title 22, California Code of Regulations (C.C.R), § 51301 *et seq.*
I. Title 28, California Code of Regulations (C.C.R), §§ 1300.75.4 through 1300.75.4.8

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VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
03/07/16	Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1998	FF.1101	Monitoring Contractor's Financial Position	Medi-Cal
Revised	06/01/2001	FF.1101	Monitoring Contractor's Financial Position	Medi-Cal
Revised	09/01/2005	FF.1101	Monitoring Contractor's Financial Position	Medi-Cal
Effective	06/01/2001	FF.1102	Monitoring Contractor's Financial Security Reserves	Medi-Cal
Effective	01/01/2007	FF.3002	Financial Oversight	Medi-Cal
Revised	01/01/2008	FF.3002	Financial Oversight	Medi-Cal
Revised	02/01/2016	FF.3002	Financial Oversight	Medi-Cal
Revised	03/01/2017	FF.3002	Financial Oversight	Medi-Cal
Revised	07/01/2018	FF.3002	Financial Oversight	Medi-Cal
Revised	TBD	FF.3002	Financial Oversight	Medi-Cal

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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.
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.
Capitation Rate	The per capita rate set by CalOptima for the delivery of Covered Services to Members 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), a physician group under a shared risk contract, or HMO, and DHCS Medi-Cal Managed Care Division Policy Letters.
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.
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 Managed Health Care (DMHC)	The State Agency responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 as amended.

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Term	Definition
Financial Solvency Reserves	Funds comprised of security reserves and/or capitation withhold that are required for the duration of a Physician Hospital Consortium's (PHC)'s, Shared Risk Group's (SRG)'s, or Health Maintenance Organization's (HMO)'s participation in the CalOptima program. These funds are used to protect the interests of and ensure the continuation of health care services to the Members assigned to the PHC, SRG or HMO; they may also be used for administrative costs directly attributable to a conservatorship, receivership or liquidation.
Financial Statement	Financial reports including balance sheets, income statements, statements of cash flows, statements of equity, and accompanying footnotes prepared in accordance with generally accepted accounting principles.
Financial Security Instrument	Time certificate of deposit, irrevocable standby letter of credit, or surety bond naming CalOptima as the beneficiary.
Focused Review	An audit that specifically targets areas of potential deficiency.
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.
Incurred But Not Reported (IBNR)	An estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network.
Knox-Keene Health Care Services Plan Act of 1975 (Knox-Keene)	The law that regulates HMOs and is administrated by the Department of Managed Health Care (DMHC), commencing with Section 1340 of the California Health and Safety Code.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Members by the total revenue received from CalOptima. Health Network medical costs would include payments to physicians (i.e. capitation, fee-for-service, or salary), medical groups/ independent practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
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).
Provider	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services.

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Term	Definition
Risk Bearing Organization (RBO)	A professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, or another lawfully organized group of physicians that: 1. Delivers, furnishes, or otherwise arranges for or provides health care services; and 2. Does all the following: a. Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees; b. Receives compensation for those services on a capitated or fixed periodic payment basis; and c. Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation payment made by the plan to the risk bearing organization.
Sanction	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, CalOptima policy, or other requirements related to CalOptima programs.
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.
Tangible Net Equity (TNE)	Net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are not past due; long term prepayments of deferred charges, and non-returnable deposits.

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Policy: FF.1010
Title: **Shared Risk Pool**
Department: Finance
Section: Accounting

CEO Approval:

Effective Date: 07/01/08
~~Last Review Date:~~ ~~10/04/18~~
~~Last~~ Revised Date: ~~10/04/18~~

~~*Board Approved Policy*~~

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I. PURPOSE

This policy outlines the process for CalOptima's administration of the Shared Risk Pool with a Shared Risk Group.

II. POLICY

A. CalOptima shall establish a Shared Risk Pool for a Shared Risk Group in accordance with the Contract for Health Care Services and the terms and conditions of this Policy.

B. CalOptima shall establish a Shared Risk Pool each fiscal year (July 1 through June 30) during the term of a Shared Risk Group's Contract for Health Care Services.

C. The Shared Risk Budget shall include:

1. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group within the applicable period;

~~2. Monies recovered by CalOptima or a Provider from Coordination of Benefits for Shared Risk Services provided to Members assigned to the Shared Risk Group, in accordance with CalOptima Policy FF.2003: Coordination of Benefits;~~

~~3.~~2. Reinsurance recovery amounts as set forth in CalOptima Policy FF.1007: Health Network Reinsurance Coverage; and

~~4.~~3. Supplemental OB Delivery Care payments as set forth in CalOptima Policy FF.1005f: Special Payments: Supplemental OB Delivery Care Payment.

D. ~~Effective on the Department of Health Care Services (DHCS) approved Whole Child Model (WCM) program implementation date, no sooner than July 1, 2019, the~~The Shared Risk Budget shall not include any amounts for Health Network Members eligible for the California Children's Services (CCS) Program.

E. Shared Risk Expenses shall include:

1. Claims paid for Shared Risk Services provided to Members assigned to the Shared Risk Group;

2. An estimate of Incurred But Not Reported (IBNR) expenses for Shared Risk Services; and

3. Administrative expenses at a rate established in the Contract for Health Care Services~~; and~~.

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~~4. Any reinsurance premiums paid by CalOptima allocable to the Shared Risk Group.~~

F. Shared Risk Expenses shall not include:

1. Reimbursement for a High Cost Exclusion Item as set forth in CalOptima Policy FF.1005c: Special Payments – High Cost Exclusion Items.

2. Any expenses attributable to the Health Network Members who are eligible for the CCS Program.

G. Quarterly Reporting - CalOptima shall report the status of the Shared Risk Pool to its corresponding Shared Risk Group within forty-five (45) calendar days following the end of each quarter as follows:

1. Quarter Ending September 30: Due November 15.

2. Quarter Ending December 31: Due February 15.

3. Quarter Ending March 31: Due May 15.

4. Quarter Ending June 30: Due August 15.

H. Semi-Annual Reconciliation and Settlement - CalOptima shall reconcile and settle the Shared Risk Pool by February 28 following the immediately preceding semi-annual period of July 1 through December 31.

1. If, at the end of the first semi-annual period of the fiscal year, CalOptima determines that the Shared Risk Pool is in surplus, CalOptima shall pay the Shared Risk Group an amount equal to sixty percent (60%) of that surplus, less any deficits carried forward from the previous annual settlement. Any surplus distributions are an advance against the projected final surplus. The remaining forty percent (40%) of the surplus shall remain in the Shared Risk Pool.

2. If, at the end of that semi-annual period, CalOptima determines that the Shared Risk Pool is in deficit, no advance payment shall be made to the Shared Risk Group.

I. Annual Reconciliation and Settlement - CalOptima shall reconcile and report the status of the Shared Risk Pool by October 31 following the end of each fiscal year. The Shared Risk Group will have thirty (30) calendar days from the date of receipt of the annual report to notify CalOptima of any objections to the calculations of the surplus or deficit, as detailed in Section III.C.4. of this Policy.

1. After issuance of the final Annual Shared Risk Program Report, if CalOptima determines that the Shared Risk Pool is in surplus, CalOptima shall pay the Shared Risk Group an amount equal to sixty percent (60%) of that surplus, less any advance amounts paid at the semi-annual reconciliation period as described in Section II.H.1. of this Policy, and less any deficits carried forward from the previous annual settlement. CalOptima shall retain the balance of the Shared Risk Pool.

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2. After issuance of the final Annual Shared Risk Program Report, if CalOptima determines that the Shared Risk Pool is in deficit, CalOptima shall carry forward an amount equal to sixty percent (60%) of that deficit into the next fiscal year's semi-annual and/or annual reconciliation, along with any additional deficits carried forward from the previous annual settlement, except as otherwise established in the Contract for Health Care Services.

J. If there is a significant change in risk pool performance, CalOptima reserves the right to meet with the Shared Risk Group in order to discuss and understand the reason for the significant change.

K. If there is continued deterioration of performance of the Shared Risk Pool, CalOptima may request a Corrective Action Plan (CAP) from the Shared Risk Group.

L. If CalOptima determines that a Shared Risk Group has Shared Risk Pool deficits in two (2) successive fiscal years, CalOptima may terminate the Shared Risk Group's Contract for Health Care Services.

M. In the event that CalOptima or a Shared Risk Group terminates the Contract for Health Care Services, CalOptima shall settle the Shared Risk Pool within one hundred twenty (120) calendar days following the date of contract termination, in accordance with Section III.D. of this Policy.

N. Upon identification of a payment error, Shared Risk Groups must submit written notification on a timely basis in order for CalOptima to seek necessary ~~provider~~Provider recoupment. CalOptima cannot request recoupment from a ~~provider~~Provider after more than three hundred sixty-five (365) calendar days from the date of CalOptima's original claims payment.

O. If a Health Network identifies an overpayment of a semi-annual or annual settlement 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.

III. PROCEDURE

A. Quarterly Shared Risk Pool Reporting

1. Within forty-five (45) calendar days following the end of each quarter, as detailed in section II.G. of this Policy, CalOptima shall provide a Shared Risk Group with a written report of the status of the Shared Risk Pool.

2. The report shall include:

a. An annualization of the aggregate amount of the Shared Risk Budget and Shared Risk Expenses for all months to date during that fiscal year; and

b. An estimate of the projected Shared Risk Pool deficit or surplus at the end of the fiscal year.

B. Semi-Annual Shared Risk Pool Reconciliation and Settlement

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1. No later than February 28 of each year, CalOptima shall settle the Shared Risk Pool for the immediately preceding semi-annual period July 1 through December 31.

    a. CalOptima shall calculate the Shared Risk Budget for the semi-annual period July 1 through December 31. The Shared Risk Budget shall include all components detailed in Sections II.C. and II.D. of this Policy related to Members assigned to the Shared Risk Group within the semi-annual period, and for dates of service within the semi-annual period.

    b. CalOptima shall calculate Shared Risk Expenses for the semi-annual period July 1 through December 31. The Shared Risk Expenses shall include all components detailed in Sections II.E. and II.F. of this Policy for dates of service within the semi-annual period.

    c. CalOptima shall reduce Shared Risk Expenses for the semi-annual period by:

        i. Any applicable copayments, deductibles, or third-party payments collected by CalOptima or a Provider for Shared Risk Services provided to Members assigned to the Shared Risk Group within the semi-annual period; and

        ii. Any recoveries, including overpayments, for dates of service within the semi-annual period related to Shared Risk Services provided to Members assigned to the Shared Risk Group.

2. CalOptima shall compute and settle the semi-annual Shared Risk Pool surplus or deficit by deducting the Shared Risk Expenses from the Shared Risk Budget for the semi-annual period.

    a. If CalOptima determines that the Shared Risk Pool is in surplus, CalOptima shall pay the Shared Risk Group an amount equal to sixty percent (60%) of that surplus, less any deficits from the previous annual settlement. Any surplus distributions are an advance against the projected final surplus. The remaining forty percent (40%) of the surplus shall remain in the Shared Risk Pool.

    b. If CalOptima determines that the Shared Risk Pool is in deficit, no advance payment shall be made to the Shared Risk Group.

C. Annual Shared Risk Pool Reconciliation and Settlement

1. No later than October 31 of each year, CalOptima shall provide the Shared Risk Group with an Annual Shared Risk Program Report. The Annual Shared Risk Program Report shall show reconciliation of allocations, deposits, expenses, and disbursements during the immediately preceding fiscal year, and the status of the Shared Risk Pool.

    a. CalOptima shall calculate the Shared Risk Budget for the annual reconciliation in accordance with Sections II.C. and II.D. of this Policy. The Shared Risk Budget for the fiscal year shall include:

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i. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group within that fiscal year, including any retroactivity within (90) calendar days after the end of the fiscal year;

~~ii. Monies recovered by CalOptima or a Provider from Coordination of Benefits for dates of service within that fiscal year and recovered within ninety (90) calendar days after the end of the fiscal year;~~

~~iii.~~ii. Reinsurance recovery amounts for dates of service within that fiscal year and identified within ninety (90) calendar days after the end of the fiscal year; and

~~iv.~~iii. Supplemental OB Delivery Care payments for dates of service within that fiscal year and identified within ninety (90) calendar days after the end of the fiscal year.

b. CalOptima shall calculate Shared Risk Expenses for the annual reconciliation in accordance with Sections II.E. and II.F. of this Policy. Shared Risk Expenses for the fiscal year shall include:

i. Claims for Shared Risk Services for dates of service within that fiscal year and paid within ninety (90) calendar days following the end of the fiscal year;

ii. An estimate of IBNR expenses for Shared Risk Services rendered within that fiscal year, based on historical claims for Shared Risk Services for dates of service within that fiscal year and paid up to ninety (90) calendar days following the end of the fiscal year; and

~~iii.~~ Administrative expenses as established in the Contract for Health Care Services~~; and~~

~~iv.~~iii. ~~Any reinsurance premiums paid by CalOptima within that fiscal year allocable to the Shared Risk Group~~.

c. Shared Risk Expenses shall not include:

i. Reimbursement for a High Cost Exclusion Item as set forth in CalOptima Policy FF.1005c: Special Payments – High Cost Exclusion Items.

d. CalOptima shall reduce Shared Risk Expenses for the fiscal year by:

i. Any applicable copayments, deductibles, or third-party payments collected by CalOptima or a Provider for Shared Risk Services provided to Members assigned to the Shared Risk Group during that fiscal year within ninety (90) calendar days after the end of the fiscal year; and

ii. Any recoveries, including overpayments, for dates of service within that fiscal year related to Shared Risk Services provided to Members assigned to the Shared Risk Group and received within ninety (90) calendar days after the end of the fiscal year.

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e. If CalOptima identifies any Shared Risk Expenses past ninety (90) calendar days following the end of the fiscal year, CalOptima shall deduct such Shared Risk Expenses from the Shared Risk Budget as part of the subsequent fiscal year's update for that Shared Risk Period pursuant to Section III.C.3. of this Policy.

2. CalOptima shall compute the annual Shared Risk Pool surplus or deficit by deducting the Shared Risk Expenses from the Shared Risk Budget for the fiscal year.

   a. If CalOptima determines that the Shared Risk Pool is in surplus, the Annual Shared Risk Program Report shall reflect that the amount payable to the Shared Risk Group will be an amount equal to sixty percent (60%) of that surplus, less any advance amounts paid at the semi-annual reconciliation period as described in Section III.B.2.a. of this Policy, and less any deficits carried forward from the previous annual settlement. CalOptima shall retain the balance of the Shared Risk Pool.

   b. If CalOptima determines that the Shared Risk Pool is in deficit, the Annual Shared Risk Program Report shall reflect that CalOptima shall carry forward an amount equal to sixty percent (60%) of that deficit into the next fiscal year's semi-annual and/or annual reconciliation, along with any additional deficits carried forward from the previous annual settlement, except as otherwise established in the Contract for Health Care Services.

3. Each Annual Shared Risk Program Report shall include refreshed reports from the previous two (2) annual shared risk periods. CalOptima shall refresh the Annual Shared Risk Program Report at the time of the following ~~Shared Risk Period's~~shared risk period's annual settlement to update IBNR and actual claims payment for previous shared risk periods. After two (2) years, the refreshed Annual Shared Risk Program Report should not contain IBNR and shall be considered final. (e.g., FY16 Shared Risk Period [July 1, 2015-June 30, 2016] will be final October 31, 2018).

4. If, upon review of the Annual Shared Risk Program Report, the Shared Risk Group objects to the calculations and determination, the Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and any supporting documentation to the CalOptima Accounting Department within thirty (30) calendar days from the date of receipt of the Annual Shared Risk Program Report.

   a. If CalOptima does not receive any written objection from the Shared Risk Group within thirty (30) calendar days of receipt of the Annual Shared Risk Program Report, CalOptima shall settle the Shared Risk Pool and apply any surplus or deficit within fifteen (15) calendar days after the expiration of the review period, no later than December 15. Such settlement shall be considered final.

   b. If CalOptima receives written notice of objection from a Shared Risk Group within the objection period, CalOptima shall re-evaluate its calculations based on additional documentation provided by the Shared Risk Group and provide a final Annual Shared Risk Program Report to the Shared Risk Group within forty-five (45) calendar days after receipt of the written objection.

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c. CalOptima shall settle the Shared Risk Pool based on this final Annual Shared Risk Program Report and apply any surplus or deficit within fifteen (15) calendar days after the date of issuance of the final Annual Shared Risk Program Report.

D. Shared Risk Pool Settlement upon Termination

1. Within one-hundred-twenty (120) calendar days after the effective date of termination of the Contract for Health Care Services with a Shared Risk Group, CalOptima shall provide the terminated Shared Risk Group with a Final Reconciliation and Settlement Report.

a. CalOptima shall calculate the Shared Risk Budget for the reconciliation upon termination in accordance with Sections II.C. and II.D. of this Policy. The Shared Risk Budget for the reconciliation upon termination shall include:

i. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group within that fiscal year and up to the effective date of termination, including any retroactivity within ninety (90) calendar days after the effective date of termination;

~~ii. Monies recovered by CalOptima or a Provider from Coordination of Benefits for dates of service within that fiscal year and up to the effective date of termination, recovered within ninety (90) calendar days after the effective date of termination;~~

~~iii.~~ii. Reinsurance coverage amounts for dates of service within the fiscal year and up to the effective date of termination, identified no later than ninety (90) calendar days after the effective date of termination; and

~~iv.~~iii. Supplemental OB Delivery Care payments for dates of service within that fiscal year and up to the effective date of termination, identified within ninety (90) calendar days after the effective date of termination.

b. CalOptima shall calculate Shared Risk Expenses for the reconciliation upon termination in accordance with Sections II.E and II.F of this Policy. Shared Risk Expenses for the reconciliation upon termination shall include:

i. Claims for Shared Risk Services for dates of service within that fiscal year and up to the effective date of termination, paid within ninety (90) calendar days following the effective date of termination;

ii. An estimate of IBNR expenses for Shared Risk Services rendered within that fiscal year and up to the effective date of termination, based on historical claims for Shared Risk Services for dates of service within that fiscal year and paid up to ninety (90) calendar days following the effective date of termination; and

~~iii.~~ Administrative expenses as established in the Contract for Health Care Services~~; and~~

~~iv.~~iii. ~~Any reinsurance premiums paid by CalOptima within that fiscal year and up to the effective date of termination allocable to the Shared Risk Group~~.

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c. Shared Risk Expenses shall not include:

i. Reimbursement for a High Cost Exclusion Item as set forth in CalOptima Policy FF.1005.c: Special Payments – High Cost Exclusion Items.

d. CalOptima shall reduce Shared Risk Expenses for the fiscal year by:

i. Any applicable copayments, deductibles, or third-party payments collected by CalOptima or a Provider for Shared Risk Services provided to Members assigned to the Shared Risk Group during that fiscal year within ninety (90) calendar days after the effective date of termination; and

ii. Any recoveries, including overpayments, for dates of service within that fiscal year and up to the effective date of termination related to Shared Risk Services provided to Members assigned to the Shared Risk Group and received within ninety (90) calendar days after the effective date of termination.

2. CalOptima shall compute the final Shared Risk Pool surplus or deficit by deducting the Shared Risk Expenses from the Shared Risk Budget for the final fiscal year.

a. If CalOptima determines that the Shared Risk Pool is in surplus, the Final Shared Risk Program Report shall reflect that the amount payable to the Shared Risk Group will be an amount equal to sixty percent (60%) of that surplus, less amounts paid at the semi-annual reconciliation period (if applicable), and less any deficits from the previous annual settlement, if not already subtracted at the semi-annual reconciliation period. CalOptima shall retain the balance of the Shared Risk Pool.

b. If CalOptima determines that the Shared Risk Pool is in deficit, the Final Shared Risk Program Report shall reflect that the Shared Risk Group shall not be responsible for any portion of that deficit.

3. If, upon review of the Final Shared Risk Program Report, the Shared Risk Group objects to the calculations and determination, the Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and any supporting documentation to the CalOptima Accounting Department within thirty (30) calendar days from the date of receipt of the Final Shared Risk Program Report.

a. If CalOptima does not receive any written objection from the Shared Risk Group within thirty (30) calendar days from the date of receipt of the Final Shared Risk Program Report, CalOptima shall settle the Shared Risk Pool and apply any surplus or deficit within fifteen (15) calendar days after the expiration of the review period. Such settlement shall be considered final.

b. If CalOptima receives written notice of objection from the Shared Risk Group, CalOptima shall re-evaluate its calculations based on additional documentation provided by the Shared Risk Group and provide any revisions to the Final Shared Risk Program Report to the Shared Risk Group within forty-five (45) calendar days after receipt of the written objection.

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c. CalOptima shall settle the Shared Risk Pool based on the revised Final Shared Risk Program Report and apply any surplus or deficit within fifteen (15) calendar days after the date of issuance of the revised Final Shared Risk Program Report.

IV. ATTACHMENT(S)

A. Risk Pool Claims Objection Form

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.1007: Health Network Reinsurance Coverage
D. CalOptima Policy FF.1005c: Special Payments – High Cost Exclusion Items
E. CalOptima Policy FF.2003: Coordination of Benefits
F. CalOptima Policy FF.1005f: Special Payments: Supplemental OB Delivery Care Payment

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
03/14/11	Department of Health Care Services

VII. BOARD ACTION(S)

Date	Meeting
10/04/18	Regular Meeting of the CalOptima Board of Directors
10/02/14	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2008	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2009	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2010	FF.1010	Shared Risk Pool	Medi-Cal
Revised	09/01/2014	FF.1010	Shared Risk Pool	Medi-Cal
Revised	08/01/2016	FF.1010	Shared Risk Pool	Medi-Cal
Revised	05/01/2017	FF.1010	Shared Risk Pool	Medi-Cal
Revised	10/04/2018	FF.1010	Shared Risk Pool	Medi-Cal
Revised		FF.1010	Shared Risk Pool	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.
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.
Contracted CalOptima Hospital	A hospital that has entered into a CalOptima Hospital Services Contract to provide hospital services to CalOptima Direct Members.
Coordination of Benefits (COB)	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.
Corrective Action Plan (CAP)	A plan delineating specific and 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 State, or designated representatives. Health Networks and Providers may be required to complete a CAP to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
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.
High Cost Exclusion Item	Specific high-cost items that are excluded from a Contracted Hospital's outpatient reimbursement or inpatient per diem rate.
Hospital Budget Capitation Allocation	The amount equal to the Hospital Risk Pool Capitation (PMPM) set forth in the contract multiplied by the number of Members assigned to the Shared Risk Physician.
Incurred But Not Reported (IBNR)	IBNR means "incurred but not reported," and refers to an estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the 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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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.
Shared Risk Budget	The total amount that CalOptima allocates to the Shared Risk Pool to pay for Shared Risk Services set forth in the DOFR of the contract.
Shared Risk Expenses	Includes: Amounts paid for Shared Risk Services provided to Members assigned to the Shared Risk Group; An estimate of Incurred But Not Reported (IBNR) expenses; and Administrative expenses at a rate established in the Contract for Health Care Services~~; and~~. ~~Any reinsurance premiums paid by CalOptima allocable to the Shared Risk Group.~~
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.
Shared Risk Pool	The risk sharing program, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima and the contracted Health Network.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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Policy: FF.1010
Title: **Shared Risk Pool**
Department: Finance
Section: Accounting

CEO Approval:

Effective Date: 07/01/08
Revised Date:

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I. PURPOSE

This policy outlines the process for CalOptima's administration of the Shared Risk Pool with a Shared Risk Group.

II. POLICY

A. CalOptima shall establish a Shared Risk Pool for a Shared Risk Group in accordance with the Contract for Health Care Services and the terms and conditions of this Policy.

B. CalOptima shall establish a Shared Risk Pool each fiscal year (July 1 through June 30) during the term of a Shared Risk Group's Contract for Health Care Services.

C. The Shared Risk Budget shall include:

1. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group within the applicable period;

2. Reinsurance recovery amounts as set forth in CalOptima Policy FF.1007: Health Network Reinsurance Coverage; and

3. Supplemental OB Delivery Care payments as set forth in CalOptima Policy FF.1005f: Special Payments: Supplemental OB Delivery Care Payment.

D. The Shared Risk Budget shall not include any amounts for Health Network Members eligible for the California Children's Services (CCS) Program.

E. Shared Risk Expenses shall include:

1. Claims paid for Shared Risk Services provided to Members assigned to the Shared Risk Group;

2. An estimate of Incurred But Not Reported (IBNR) expenses for Shared Risk Services; and

3. Administrative expenses at a rate established in the Contract for Health Care Services.

F. Shared Risk Expenses shall not include:

1. Reimbursement for a High Cost Exclusion Item as set forth in CalOptima Policy FF.1005c: Special Payments – High Cost Exclusion Items.

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2. Any expenses attributable to the Health Network Members who are eligible for the CCS Program.

G. Quarterly Reporting - CalOptima shall report the status of the Shared Risk Pool to its corresponding Shared Risk Group within forty-five (45) calendar days following the end of each quarter as follows:

1. Quarter Ending September 30: Due November 15.

2. Quarter Ending December 31: Due February 15.

3. Quarter Ending March 31: Due May 15.

4. Quarter Ending June 30: Due August 15.

H. Semi-Annual Reconciliation and Settlement - CalOptima shall reconcile and settle the Shared Risk Pool by February 28 following the immediately preceding semi-annual period of July 1 through December 31.

1. If, at the end of the first semi-annual period of the fiscal year, CalOptima determines that the Shared Risk Pool is in surplus, CalOptima shall pay the Shared Risk Group an amount equal to sixty percent (60%) of that surplus, less any deficits carried forward from the previous annual settlement. Any surplus distributions are an advance against the projected final surplus. The remaining forty percent (40%) of the surplus shall remain in the Shared Risk Pool.

2. If, at the end of that semi-annual period, CalOptima determines that the Shared Risk Pool is in deficit, no advance payment shall be made to the Shared Risk Group.

I. Annual Reconciliation and Settlement - CalOptima shall reconcile and report the status of the Shared Risk Pool by October 31 following the end of each fiscal year. The Shared Risk Group will have thirty (30) calendar days from the date of receipt of the annual report to notify CalOptima of any objections to the calculations of the surplus or deficit, as detailed in Section III.C.4. of this Policy.

1. After issuance of the final Annual Shared Risk Program Report, if CalOptima determines that the Shared Risk Pool is in surplus, CalOptima shall pay the Shared Risk Group an amount equal to sixty percent (60%) of that surplus, less any advance amounts paid at the semi-annual reconciliation period as described in Section II.H.1. of this Policy, and less any deficits carried forward from the previous annual settlement. CalOptima shall retain the balance of the Shared Risk Pool.

2. After issuance of the final Annual Shared Risk Program Report, if CalOptima determines that the Shared Risk Pool is in deficit, CalOptima shall carry forward an amount equal to sixty percent (60%) of that deficit into the next fiscal year's semi-annual and/or annual reconciliation, along with any additional deficits carried forward from the previous annual settlement, except as otherwise established in the Contract for Health Care Services.

J. If there is a significant change in risk pool performance, CalOptima reserves the right to meet with the Shared Risk Group in order to discuss and understand the reason for the significant change.

K. If there is continued deterioration of performance of the Shared Risk Pool, CalOptima may request a Corrective Action Plan (CAP) from the Shared Risk Group.

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L. If CalOptima determines that a Shared Risk Group has Shared Risk Pool deficits in two (2) successive fiscal years, CalOptima may terminate the Shared Risk Group's Contract for Health Care Services.

M. In the event that CalOptima or a Shared Risk Group terminates the Contract for Health Care Services, CalOptima shall settle the Shared Risk Pool within one hundred twenty (120) calendar days following the date of contract termination, in accordance with Section III.D. of this Policy.

N. Upon identification of a payment error, Shared Risk Groups must submit written notification on a timely basis in order for CalOptima to seek necessary Provider recoupment. CalOptima cannot request recoupment from a Provider after more than three hundred sixty-five (365) calendar days from the date of CalOptima's original claims payment.

O. If a Health Network identifies an overpayment of a semi-annual or annual settlement 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.

III. PROCEDURE

A. Quarterly Shared Risk Pool Reporting

1. Within forty-five (45) calendar days following the end of each quarter, as detailed in section II.G. of this Policy, CalOptima shall provide a Shared Risk Group with a written report of the status of the Shared Risk Pool.

2. The report shall include:

   a. An annualization of the aggregate amount of the Shared Risk Budget and Shared Risk Expenses for all months to date during that fiscal year; and

   b. An estimate of the projected Shared Risk Pool deficit or surplus at the end of the fiscal year.

B. Semi-Annual Shared Risk Pool Reconciliation and Settlement

1. No later than February 28 of each year, CalOptima shall settle the Shared Risk Pool for the immediately preceding semi-annual period July 1 through December 31.

   a. CalOptima shall calculate the Shared Risk Budget for the semi-annual period July 1 through December 31. The Shared Risk Budget shall include all components detailed in Sections II.C. and II.D. of this Policy related to Members assigned to the Shared Risk Group within the semi-annual period, and for dates of service within the semi-annual period.

   b. CalOptima shall calculate Shared Risk Expenses for the semi-annual period July 1 through December 31. The Shared Risk Expenses shall include all components detailed in Sections II.E. and II.F. of this Policy for dates of service within the semi-annual period.

   c. CalOptima shall reduce Shared Risk Expenses for the semi-annual period by:

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i. Any applicable copayments, deductibles, or third-party payments collected by CalOptima or a Provider for Shared Risk Services provided to Members assigned to the Shared Risk Group within the semi-annual period; and

ii. Any recoveries, including overpayments, for dates of service within the semi-annual period related to Shared Risk Services provided to Members assigned to the Shared Risk Group.

2. CalOptima shall compute and settle the semi-annual Shared Risk Pool surplus or deficit by deducting the Shared Risk Expenses from the Shared Risk Budget for the semi-annual period.

a. If CalOptima determines that the Shared Risk Pool is in surplus, CalOptima shall pay the Shared Risk Group an amount equal to sixty percent (60%) of that surplus, less any deficits from the previous annual settlement. Any surplus distributions are an advance against the projected final surplus. The remaining forty percent (40%) of the surplus shall remain in the Shared Risk Pool.

b. If CalOptima determines that the Shared Risk Pool is in deficit, no advance payment shall be made to the Shared Risk Group.

C. Annual Shared Risk Pool Reconciliation and Settlement

1. No later than October 31 of each year, CalOptima shall provide the Shared Risk Group with an Annual Shared Risk Program Report. The Annual Shared Risk Program Report shall show reconciliation of allocations, deposits, expenses, and disbursements during the immediately preceding fiscal year, and the status of the Shared Risk Pool.

a. CalOptima shall calculate the Shared Risk Budget for the annual reconciliation in accordance with Sections II.C. and II.D. of this Policy. The Shared Risk Budget for the fiscal year shall include:

i. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group within that fiscal year, including any retroactivity within (90) calendar days after the end of the fiscal year;

ii. Reinsurance recovery amounts for dates of service within that fiscal year and identified within ninety (90) calendar days after the end of the fiscal year; and

iii. Supplemental OB Delivery Care payments for dates of service within that fiscal year and identified within ninety (90) calendar days after the end of the fiscal year.

b. CalOptima shall calculate Shared Risk Expenses for the annual reconciliation in accordance with Sections II.E. and II.F. of this Policy. Shared Risk Expenses for the fiscal year shall include:

i. Claims for Shared Risk Services for dates of service within that fiscal year and paid within ninety (90) calendar days following the end of the fiscal year;

ii. An estimate of IBNR expenses for Shared Risk Services rendered within that fiscal year, based on historical claims for Shared Risk Services for dates of service within that fiscal year and paid up to ninety (90) calendar days following the end of the fiscal year; and

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iii. Administrative expenses as established in the Contract for Health Care Services.

c. Shared Risk Expenses shall not include:

i. Reimbursement for a High Cost Exclusion Item as set forth in CalOptima Policy FF.1005c: Special Payments – High Cost Exclusion Items.

d. CalOptima shall reduce Shared Risk Expenses for the fiscal year by:

i. Any applicable copayments, deductibles, or third-party payments collected by CalOptima or a Provider for Shared Risk Services provided to Members assigned to the Shared Risk Group during that fiscal year within ninety (90) calendar days after the end of the fiscal year; and

ii. Any recoveries, including overpayments, for dates of service within that fiscal year related to Shared Risk Services provided to Members assigned to the Shared Risk Group and received within ninety (90) calendar days after the end of the fiscal year.

e. If CalOptima identifies any Shared Risk Expenses past ninety (90) calendar days following the end of the fiscal year, CalOptima shall deduct such Shared Risk Expenses from the Shared Risk Budget as part of the subsequent fiscal year's update for that Shared Risk Period pursuant to Section III.C.3. of this Policy.

2. CalOptima shall compute the annual Shared Risk Pool surplus or deficit by deducting the Shared Risk Expenses from the Shared Risk Budget for the fiscal year.

a. If CalOptima determines that the Shared Risk Pool is in surplus, the Annual Shared Risk Program Report shall reflect that the amount payable to the Shared Risk Group will be an amount equal to sixty percent (60%) of that surplus, less any advance amounts paid at the semi-annual reconciliation period as described in Section III.B.2.a. of this Policy, and less any deficits carried forward from the previous annual settlement. CalOptima shall retain the balance of the Shared Risk Pool.

b. If CalOptima determines that the Shared Risk Pool is in deficit, the Annual Shared Risk Program Report shall reflect that CalOptima shall carry forward an amount equal to sixty percent (60%) of that deficit into the next fiscal year's semi-annual and/or annual reconciliation, along with any additional deficits carried forward from the previous annual settlement, except as otherwise established in the Contract for Health Care Services.

3. Each Annual Shared Risk Program Report shall include refreshed reports from the previous two (2) annual shared risk periods. CalOptima shall refresh the Annual Shared Risk Program Report at the time of the following shared risk period's annual settlement to update IBNR and actual claims payment for previous shared risk periods. After two (2) years, the refreshed Annual Shared Risk Program Report should not contain IBNR and shall be considered final. (e.g., FY16 Shared Risk Period [July 1, 2015-June 30, 2016] will be final October 31, 2018).

4. If, upon review of the Annual Shared Risk Program Report, the Shared Risk Group objects to the calculations and determination, the Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and any supporting documentation to the CalOptima Accounting Department within thirty (30) calendar days from the date of receipt of the Annual Shared Risk Program Report.

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a. If CalOptima does not receive any written objection from the Shared Risk Group within thirty (30) calendar days of receipt of the Annual Shared Risk Program Report, CalOptima shall settle the Shared Risk Pool and apply any surplus or deficit within fifteen (15) calendar days after the expiration of the review period, no later than December 15. Such settlement shall be considered final.

b. If CalOptima receives written notice of objection from a Shared Risk Group within the objection period, CalOptima shall re-evaluate its calculations based on additional documentation provided by the Shared Risk Group and provide a final Annual Shared Risk Program Report to the Shared Risk Group within forty-five (45) calendar days after receipt of the written objection.

c. CalOptima shall settle the Shared Risk Pool based on this final Annual Shared Risk Program Report and apply any surplus or deficit within fifteen (15) calendar days after the date of issuance of the final Annual Shared Risk Program Report.

D. Shared Risk Pool Settlement upon Termination

1. Within one-hundred-twenty (120) calendar days after the effective date of termination of the Contract for Health Care Services with a Shared Risk Group, CalOptima shall provide the terminated Shared Risk Group with a Final Reconciliation and Settlement Report.

a. CalOptima shall calculate the Shared Risk Budget for the reconciliation upon termination in accordance with Sections II.C. and II.D. of this Policy. The Shared Risk Budget for the reconciliation upon termination shall include:

i. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group within that fiscal year and up to the effective date of termination, including any retroactivity within ninety (90) calendar days after the effective date of termination;

ii. Reinsurance coverage amounts for dates of service within the fiscal year and up to the effective date of termination, identified no later than ninety (90) calendar days after the effective date of termination; and

iii. Supplemental OB Delivery Care payments for dates of service within that fiscal year and up to the effective date of termination, identified within ninety (90) calendar days after the effective date of termination.

b. CalOptima shall calculate Shared Risk Expenses for the reconciliation upon termination in accordance with Sections II.E and II.F of this Policy. Shared Risk Expenses for the reconciliation upon termination shall include:

i. Claims for Shared Risk Services for dates of service within that fiscal year and up to the effective date of termination, paid within ninety (90) calendar days following the effective date of termination;

ii. An estimate of IBNR expenses for Shared Risk Services rendered within that fiscal year and up to the effective date of termination, based on historical claims for Shared Risk Services for dates of service within that fiscal year and paid up to ninety (90) calendar days following the effective date of termination; and

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iii. Administrative expenses as established in the Contract for Health Care Services.

c. Shared Risk Expenses shall not include:

i. Reimbursement for a High Cost Exclusion Item as set forth in CalOptima Policy FF.1005.c: Special Payments – High Cost Exclusion Items.

d. CalOptima shall reduce Shared Risk Expenses for the fiscal year by:

i. Any applicable copayments, deductibles, or third-party payments collected by CalOptima or a Provider for Shared Risk Services provided to Members assigned to the Shared Risk Group during that fiscal year within ninety (90) calendar days after the effective date of termination; and

ii. Any recoveries, including overpayments, for dates of service within that fiscal year and up to the effective date of termination related to Shared Risk Services provided to Members assigned to the Shared Risk Group and received within ninety (90) calendar days after the effective date of termination.

2. CalOptima shall compute the final Shared Risk Pool surplus or deficit by deducting the Shared Risk Expenses from the Shared Risk Budget for the final fiscal year.

a. If CalOptima determines that the Shared Risk Pool is in surplus, the Final Shared Risk Program Report shall reflect that the amount payable to the Shared Risk Group will be an amount equal to sixty percent (60%) of that surplus, less amounts paid at the semi-annual reconciliation period (if applicable), and less any deficits from the previous annual settlement, if not already subtracted at the semi-annual reconciliation period. CalOptima shall retain the balance of the Shared Risk Pool.

b. If CalOptima determines that the Shared Risk Pool is in deficit, the Final Shared Risk Program Report shall reflect that the Shared Risk Group shall not be responsible for any portion of that deficit.

3. If, upon review of the Final Shared Risk Program Report, the Shared Risk Group objects to the calculations and determination, the Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and any supporting documentation to the CalOptima Accounting Department within thirty (30) calendar days from the date of receipt of the Final Shared Risk Program Report.

a. If CalOptima does not receive any written objection from the Shared Risk Group within thirty (30) calendar days from the date of receipt of the Final Shared Risk Program Report, CalOptima shall settle the Shared Risk Pool and apply any surplus or deficit within fifteen (15) calendar days after the expiration of the review period. Such settlement shall be considered final.

b. If CalOptima receives written notice of objection from the Shared Risk Group, CalOptima shall re-evaluate its calculations based on additional documentation provided by the Shared Risk Group and provide any revisions to the Final Shared Risk Program Report to the Shared Risk Group within forty-five (45) calendar days after receipt of the written objection.

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c. CalOptima shall settle the Shared Risk Pool based on the revised Final Shared Risk Program Report and apply any surplus or deficit within fifteen (15) calendar days after the date of issuance of the revised Final Shared Risk Program Report.

IV. ATTACHMENT(S)

A. Risk Pool Claims Objection Form

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.1007: Health Network Reinsurance Coverage
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F. CalOptima Policy FF.1005f: Special Payments: Supplemental OB Delivery Care Payment

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
03/14/11	Department of Health Care Services

VII. BOARD ACTION(S)

Date	Meeting
10/04/18	Regular Meeting of the CalOptima Board of Directors
10/02/14	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2008	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2009	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2010	FF.1010	Shared Risk Pool	Medi-Cal
Revised	09/01/2014	FF.1010	Shared Risk Pool	Medi-Cal
Revised	08/01/2016	FF.1010	Shared Risk Pool	Medi-Cal
Revised	05/01/2017	FF.1010	Shared Risk Pool	Medi-Cal
Revised	10/04/2018	FF.1010	Shared Risk Pool	Medi-Cal
Revised		FF.1010	Shared Risk Pool	Medi-Cal

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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.
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Hospital Budget Capitation Allocation	The amount equal to the Hospital Risk Pool Capitation (PMPM) set forth in the contract multiplied by the number of Members assigned to the Shared Risk Physician.
Incurred But Not Reported (IBNR)	IBNR means "incurred but not reported," and refers to an estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the 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.
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 Budget	The total amount that CalOptima allocates to the Shared Risk Pool to pay for Shared Risk Services set forth in the DOFR of the contract.

For 20200604 BOD Review Only

Term	Definition
Shared Risk Expenses	Includes: Amounts paid for Shared Risk Services provided to Members assigned to the Shared Risk Group; An estimate of Incurred But Not Reported (IBNR) expenses; and Administrative expenses at a rate established in the Contract for Health Care 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.
Shared Risk Pool	The risk sharing program, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima and the contracted Health Network.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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Hospital Shared Risk Pool
Shared Risk Group: _____
Risk Pool Period
Date of Service: _____
Date of Payment: _____

Line Of Business
- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect

Item #	Payment Question/Issue	CalOptima Claim No.	Member Name	Provider Name	Start Date of Service	End Date of Service	Amount Paid	Date of Payment	Requested Credit	CalOptima Review	2nd Level CalOptima GARS Appeal Review	CalOptima Potential Claim Overpayment
							$ -		$ -			$ -

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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.

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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.

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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

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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**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates	5785 Corporate Ave. ~~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

For 20200604 BOD Review Only

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima shall administer Directed Payments for Qualifying Services rendered to CalOptima Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima claims and utilization management policies, including but not limited to CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Direct or a Shared Risk Group on the date of service.

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3. The Designated Provider was eligible to receive the Directed Payment.

4. The Qualifying Services were rendered by a Designated Provider on an eligible date of service.

C. For Qualifying Services rendered to Shared Risk Group Members, only GEMT Services are eligible for Directed Payments pursuant to this Policy. Such eligibility is subject to change based on whether CalOptima is financially responsible under the Shared Risk Group contract DOFR.

D. CalOptima shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy, including Attachment A 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

For 20201604 BOD Review Only

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.

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f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. 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.

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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.

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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

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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

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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				

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IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
CalOptima Direct	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.

For 20200604 BOD Review Only

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program 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.

For 2020060A BOD Review Only

Term	Definition
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Eligible Contracted Provider	An individual rendering Provider who is contracted with CalOptima to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to CalOptima Direct and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with CalOptima does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
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.

For 20200604 BOD Review Only

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.

For 2020604 BOD Review Only

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[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

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	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*

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **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*

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

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

For 20200604 BOD Review Only

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.

For 20200604 BOD Review Only

~~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

For 20200604 BOD Review Only

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.

For 2020/05/04 BOD Review Only

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.

For 20200604 BOD Review Only

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

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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

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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.

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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

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I. PURPOSE

This policy outlines CalOptima's payment methodologies for a Provider or Practitioner that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. 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:

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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.

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viii. CalOptima shall reimburse Family Planning Services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a) CalOptima shall reimburse ~~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.

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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

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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

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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

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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

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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

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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.

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Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program~~,~~ (as set forth in Title 22, ~~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.

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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.

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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.

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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

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I. PURPOSE

This policy outlines CalOptima's payment methodologies for a Provider or Practitioner that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. 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.

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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

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DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a) CalOptima shall reimburse a provider, including a non-contracted provider, for a (12)-month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches, or hormone-containing contraceptive vaginal rings when dispensed at one time at a Member's request by a qualified family planning provider or pharmacist with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwife and licensed midwives services as permitted within each practitioner's scope of practice, CalOptima shall reimburse facility and professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

D. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an FQHC that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible, as follows:

1. Contracted FQHC: CalOptima shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and CalOptima. CalOptima's contracted rates for an FQHC shall not be less than CalOptima's contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC:

a. CalOptima shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

i. CalOptima shall reimburse a non-contracted FQHC for CHDP services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

ii. CalOptima shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

E. American Indian Health Service Program Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Indian Health Service Facility that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible as follows:

1. Contracted American Indian Health Service Program:

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a. If the American Indian Health Service Program is a Rural Health Clinic or qualifies as an FQHC, CalOptima shall reimburse the program at the program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

b. If the American Indian Health Service Program is a Rural Health Clinic or FQHC, and CalOptima and the program have agreed to an at-risk rate and the program has waived its rights to cost-based reimbursement under its contract with CalOptima, CalOptima shall reimburse the program at the negotiated rate.

c. If the American Indian Health Service Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, CalOptima shall reimburse the program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service Program: CalOptima shall reimburse a non-contracted American Indian Health Service Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, CalOptima shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register. These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. CalOptima shall ensure that the following criteria are met for receipt of payments:

a. The American Indian Health Service Program provider must be identified by DHCS;

b. Service must be a Covered Service included in CalOptima's contract with DHCS;

c. 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.

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2. CalOptima shall reimburse a non-contracted ancillary service provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

G. Directed Payment: CalOptima shall make specified directed payments to a Provider or Practitioner eligible to receive the directed payments for qualifying Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for which CalOptima is financially responsible, in accordance with the requirements of CalOptima Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to a Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services.

H. 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

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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
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-008: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network Border Hospitals Under the Diagnostic Related Group Payment Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020

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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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10/04/2018	Regular Meeting of the CalOptima Board of Directors
06/06/2019	Regular Meeting of the CalOptima Board of Directors

FOR 20200604 BOD Review Only

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.

For 20200604 BOD Review Only

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and 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.

For 20200604 BOD Review Only

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.

For 20200604 BOD Preview Only

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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.

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- 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 — **Authorized Signature**

5/30/2018 — **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

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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.

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- 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 — **Authorized Signature**

5/30/2018 — **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.

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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**

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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.

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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.

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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

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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.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Consider Approval of the 2019 CalOptima Utilization Management (UM) Program Evaluation and the 2020 CalOptima UM Program

Contact

Tracy Hitzeman, RN, Executive Director Clinical Operations (714) 246-8400
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action

Approve the 2019 Utilization Management (UM) Program Evaluation and the 2020 UM Program.

Background

Utilization Management activities are conducted to ensure that members' needs are always at the forefront of any determination regarding care and services. The program is established and conducted as part of CalOptima's purpose and mission to ensure the consistent delivery of medically necessary, quality health care services. It provides for the delivery of care in a coordinated, comprehensive and culturally competent manner. It also ensures that medical decision making is not influenced by financial considerations, does not reward practitioners or other individuals for issuing denials of coverage, nor does the program encourage decisions that result in underutilization. Additionally, the Utilization Management Program is conducted to ensure compliance with CalOptima's obligations to meet contractual, regulatory and accreditation requirements.

CalOptima's Utilization Management Program ("the UM Program") must be reviewed and evaluated annually by the Board of Directors. The UM Program defines the structure within which utilization management activities are conducted, and establishes processes for systematically coordinating, managing and monitoring these processes to achieve positive member outcomes.

CalOptima staff has updated the 2020 UM Program Description to ensure that it is aligned to reflect health network and strategic organizational changes. This will ensure that all regulatory and NCQA accreditation standards are met in a consistent manner across the Medi-Cal, OneCare and OneCare Connect programs.

Discussion

The 2020 Utilization Management Evaluation analyzes CalOptima's performance against 2019-approved goals in two general areas: Operational Performance and Outcomes. CalOptima successfully transitioned members eligible with the California Children's Services Program (CCS) to the Whole Child Model (WCM) Program on July 1, 2019.

The 2020 Utilization Management Program is based on the Board-approved 2019 Utilization Management Program and describes: (i) the scope of the program; (ii) the progam structure and services provided; (iii) the populations served; (iv) key business processes; (v) integration across CalOptima; and

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(vi) important aspects of care and service for all lines of business. It is consistent with regulatory requirements, NCQA standards and CalOptima's own Success Factors.
The revisions are summarized as follows:

1. Aligned program descriptions and committee references with the Quality Management Program and approved committee charter updates.
2. Updated CalOptima's Population Health Management strategy to include four key strategies: keeping members healthy, managing members through emerging risk, patient safety or outcomes across settings and managing multiple chronic conditions.
3. Added CalOptima's Health Homes Program and Homeless Health Initiatives to the UM Program including five components: behavioral health, health care, housing support services, community connections and public social services.
4. Added role of the Deputy Chief Medical Officer and updated the description of responsibilities for various key positions.

The changes recommended to CalOptima's UM Program are reflective of current clinical operations and are necessary to meet the requirements specified by the Centers for Medicare & Medicaid Services, California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact
There is no fiscal impact.

Concurrence
CalOptima Utilization Management Subcommittee
Board of Directors' Quality Assurance Committee

Attachments
1. CalOptima Annual Review 2019 UM Program Evaluation and 2020 Program
2. 2019 UM Program Evaluation FINAL DRAFT redline
3. 2019 UM Program Evaluation FINAL DRAFT clean
4. 2020 UM Program DRAFT FINAL redline
5. 2020 UM Program DRAFT FINAL clean

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

CalOptima
A Public Agency
Better. Together.

Annual Review: 2019 & 2020 UM Program

Quality Assurance Committee

May 20, 2020

Tracy Hitzeman, RN

Executive Director Clinical Services

2019 UM Program Evaluation

- Annual evaluation approved by UMC and QIC
  - Analyzes plan performance against 2019-approved goals in two general areas:
    - Operational Performance
    - Outcomes
  - Includes status of focused initiatives described in the 2019 UM Program Description
  - Informs areas of opportunity to address in 2020 UM Program

2020 UM Program Description

- Identify and include in 2020 UM Program:
  - Any changes in program structure
  - Those responsible for the UM program
  - Any new initiatives/programs, and
  - Any changes to the program scope and processes used to determine benefit coverage and medical necessity

2019 UM Program Evaluation

- Accomplishments:
  - Successful transition on July 1, 2019 of CalOptima members eligible with the California Children's Services Program (CCS) to the Whole Child Model (WCM) Program.
  - Improved timeliness of COD expedited request processing, exceeding goal of 98% for all of 2019 for Medi-Cal and OneCare.
  - Maintained excellent timeliness of COD routine request processing, with an average of 99.95% within turn-around-times

2019 UM Program Evaluation

- Opportunities:
  - Improve visibility of operational performance of direct and delegated Health Networks (HNs) operational performance as evidenced by transparency between the Audit and Oversight and UM Department audits and monitoring efforts.
  - Strengthen monitoring and auditing functions through inter-rater education and identification of “best practices.”

2020 UM Program Description

- The following slides are a summary of all substantive updates

Program Section	Change	Rationale for Change
Signature Page	Replaced Dr Federico with Dr Dajee	Current UMC Chair
Homeless Health Initiative	Added this program to the 2020 description. System of care developed to respond to the needs of the Orange County homeless. Includes five components: behavioral health; health care; housing support services; community connections; and public social services	New program as of 1/20/2020
Population Health Management (PHM)	Updated PHM strategy focus for CalOptima to include 4 key strategies: keeping members healthy; managing members though emerging risks; patient safety or outcomes across settings; and managing multiple chronic conditions	Reflect updated PHM strategy for 2021
UM Program Structure	Program structure summary updated to include specifics regarding our collaborative nature with our delegated partners, care and service providers; overview of reporting structure through the organization chart and committee structures; and ongoing nature of the evaluation of the program	Summarize the major components of the UM program structure.
Behavioral Health (BH) Services: OC/OCC	OC/OCC BH services managed by CalOptima effective 1/01/2020.	Important change of BH services now managed by CalOptima

2020 UM Program Description (cont.)

Program Section	Change	Rationale for Change
Board of Directors	Added verbiage regarding the Ralph M Brown Act, that Board meetings are opened to the public. Also outlined that the Board of Directors' Quality Assurance Committee (QAC) role is to make recommendations to CalOptima's Board of Directors (BOD) regarding the Quality Improvement Program and outlined the Quadruple Aim, which was an expansion of the Triple Aim. Included several advisory committee's that ensure the provision of services with public input such as: Member Advisory Committee, OCC Member Advisory Committee, Provider Advisory Committee and the Whole-Child Model Family Advisory Committee. These advisory committee's report up to the CalOptima BOD and are open to the public	Identifies important advisory committees integral to CalOptima
Role of CalOptima Officers	Added role of the Deputy Chief Medical Officer in the UM program and plan, as well as description of responsibilities of the CEO/COO.	Ensure program reflected all staff involved in administration of the program

2020 UM Program Description (cont.)

Program Section	Change	Rationale for Change
Medical Director, Behavioral Health	Enhanced language to clarify the role in the QI and UM programs and the role of chair of Pharmacy & Therapeutics Committee	Ensure inclusion of all roles and responsibilities
Director, Utilization Management	Added verbiage that called out the roles of this position	Ensure inclusion of all roles and responsibilities
Behavioral Health Integration (BHI) Resources	Clarified roles in the BHI department to ensure each position reflects duties and job requirements. Included qualifications, training and supervisory responsibilities of appropriate roles	Ensure accurate identification of job duties and requirements per role
Committee Organization Structure Diagram	Removal of LTSS QI Subcommittee and Behavioral Health Quality QI Subcommittee. Removed explanations of each subcommittee below it, due to sunsetting	Subcommittees sunsetted and activities captured through UMC and Quality Improvement Committee (QIC) reporting

2020 UM Program Description (cont.)

Program Section	Change	Rationale for Change
Integration with Other Processes	Important updates to demonstrate how UM integrates with other programs within CalOptima, as well as coordinates with and local community programs that take care of our members.	Collaboration internally and externally are critical for the success of CalOptima programs
Review and authorization of services	Updated the definition of medical necessity review, as well as specific updates to the Medi-Cal medical necessity reviews, MLTSS and members < 21 years old. Specific Medicare verbiage regarding medical necessity that is reasonable and necessary for diagnosis or treatment or to improve function	Critical to ensure the definition and requirements per LOB is accurate and clear
Behavioral Health Determinations	Information about the management of OC/OCC line of business (LOB) effective 1/1/2020. It included services such as prior auth review for covered services and those cases requiring authorization. Also indicated the criterion for making BHI medical necessity reviews such as MCG Health, Dual Plan Letters (DPL) and CalOptima policies	Important information regarding the management of these services brought in house 1/01/2020
UM Criteria	Updated the hierarchy of clinical decision making to include references to sources of criteria, in order, for each LOB	Specifics by LOB will help the reviewer understand the appropriate sequence in applying criteria

2020 UM Program Description (cont.)

Program Section	Change	Rationale for Change
Practitioner and member access to criteria	Update to include provider annual training regarding UM processes and submission of referrals to CalOptima	Additional information on annual trainings provided to the network
Timeliness of UM Decisions	Updated Medi-Cal routine referrals to be completed within 5 working days of receipt of all information reasonably necessary to render a decision, but no longer than 14 days following receipt of request	Critical to be sure there is a thorough understanding of regulatory requirements on decision making time frames
Authorization for Post-Stabilization Services	Clarified that for Medi-Cal, a decision must be made within 30 minutes after receiving a Prior Authorization Request for Post-Stabilization Services (PSA) and all information reasonably necessary to render a decision; For OneCare or OneCare Connect, a decision must be made within 60 minutes after receiving such request and information.	Clarity on decision making requirements for PSA requests
Hospitalist/ SNFist program	Removed verbiage as CalOptima does not have a program at this time	Ensure accuracy of programs contained within the description

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.

~~2018~~2019 ~~-~~CalOptima Utilization Management Program Evaluation

~~January 7, 2019~~

Executive Summary

The ~~2018~~2019 Utilization Management (UM) Program ~~and Work Plan~~ describe~~s~~ CalOptima's activities to promote optimum utilization of health care services for our members delivered in a high-quality, compassionate and cost-effective manner.

This evaluation of UM activity is completed annually and approved by the Utilization Management Committee (UMC), the Quality Improvement Committee (QIC), the Quality Assurance Committee (QAC) and CalOptima's Board of Directors.

There have been no changes to the overall UM program structure elements listed below during 2019. The program structure elements are:

- UM staff assigned activities~~;~~,
- UM staff who have the authority to deny coverage~~;~~,
- Involvement of a designated physician and a designated behavioral healthcare practitioner~~;~~,
- The process for evaluating, approving and revising the UM program, and those responsible for each step;
- The UM program's role in the QI program, including how the organization collects UM information and uses it for QI activities~~;~~, ~~and~~
- The process for handling appeals and making appeal determinations.

~~I.~~ Projects, Programs and Initiatives:

A. Utilization Management

In ~~2018~~2019, the UM department initiated several projects to support improved efficiency, decreased administrative burden and improved quality of provider and member facing documentation. These projects included:

- Upgrades/enhancements to the Guiding ~~(GC)~~ Care (GC) Utilization Review Module in CalOptima's medical management system
- ~~Provider Data clean-up project – coordination with the Process Excellence department~~
- Desktop Procedures – cataloged, reviewed and updated
- ~~Added a UM Data Analyst to enhance monitoring and reporting activities~~
- Continued development of CalOptima Reporting Environment (CORE) to align operational reports with the data structure in GC and to continue to identify opportunities for process

improvement

- ~~Conducted an in-depth review of the California Children's Services Program and initiated groundwork for the transition to the Whole-Child Model~~Successful transition on July 1, 2019 of CalOptima members eligible with the California Children's Services Program (CCS) to the Whole Child Model (WCM) Program.
- Ensured all policies and procedures were in effect in accordance with regulatory requirements and accurately represent clinical operations processes~~.~~.

The Medical Director of UM provides clinical oversight for the administration of the UM ~~Program~~Program and has been very engaged during 2019. He/s~~S~~he supports the UM process by ensuring that treatment requests are processed in accordance with regulatory, contractual and accreditation guidelines and clinical evidence-based criteria, and by evaluating the program's effectiveness against established goals. For UM Program areas that do not meet the approved goals, modifications to program activities are proposed by leadership to the UM Workgroup (UMWG). As endorsed by the UMWG, the updated plan is presented and approved by the Utilization Management Committee (UMC). These changes are implemented by the UM Leadership and department staff. The UM Medical Director supports provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee (BMSC). This subcommittee evaluates new and modified benefits to determine the need for prior authorization. He/s~~S~~he also chairs the bi-weekly UMWG, whicho~~~~ provides input to the development and processes of UM Program ~~and UM Work Plan~~ to ensure quality, cost efficient services~~,~~ and care are delivered to CalOptima members. The UM Medical Director led discussions with the nursing and physician group in semiweekly concurrent review case rounds, discussing appropriate care guidelines, clinical and practical aspects of managing medically complex members in the acute and post-acute care settings and assisting with discharge planning management. He also provided education to the team to ensure understanding of the clinical basis for decisions.

DRAFT

The UM Medical Director also provided focused education on specific topics including: genetic testing, transgender procedures, management of administrative days, appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria, the Letter of Agreement (LOA) process, and evaluation of the appropriateness of one-day inpatient stays.

In ~~2018~~2019, the UM Medical Director adequately supported the UM process and met the needs of the UM team through education, case review and availability.

B. Behavioral Health Integration

In 2019, CalOptima ~~Effective January 1, 2018, CalOptima began to~~ continued to manage all the administrative functions of Medi-Cal mild to moderate mental health benefits and behavioral health treatment (BHT) services for CalOptima members, including UM, claims, provider network, credentialing, member services, care coordination, and Quality Improvement (QI. ~~). In addition, on July 1, 2018, members 20 years of age and younger who were not diagnosed with an Autism Spectrum Disorder and were receiving BHT services through the Regional Center of Orange County (RCOC) began transitioning to CalOptima.~~ The Behavioral Health Integration (BHI) department worked closely with other departments to ensure the provision of treatment was in accordance with mental health parity legislation and the prior authorization process complied with all federal, state, contractual, regulatory and accreditation guidelines. ~~The Medi-Cal and BHT transition went smoothly with minimum possible disruption to our members.~~

For OneCare (OC) and OneCare Connect (OCC), Magellan Health served as CalOptima's Managed Behavioral Health Organization (MBHO) with the full spectrum of administrative responsibilities including UM, provider network, credentialing, customer service, inpatient services, and care coordination. BHI maintained a close working relationship with Health Network (HN) management, providing oversight of the MBHO's delivery of the mental health services and administrative functions.

The Behavioral Health Quality Improvement (BHQI) Subcommittee was held on a quarterly basis and reported to the Quality Improvement Committee (QIC). The BHQI trends, analyzes and identifies improvement areas for behavioral health (BH) services, ensures access to quality BH care, and enhances continuity and coordination between behavioral health and physical health care providers The BHQI is chaired by the BH Medical Director and is comprised of internal and external members, which include delegated health network participants, community partners, behavioral health practitioners, and the Orange County Mental Health Plan (MHP), administered by the Orange County Health Care Agency (OC HCA). The chair is responsible for leading and presenting subcommittee recommendations to the QIC. In addition, a BHQI workgroup met regularly throughout ~~2018~~2019 for additional work and analysis on BH quality initiatives. This group served to address suggestions from the BHQI that assisted with strengthening interventions, data review and key areas for improving the member experience. In ~~2018~~2019, the BH Medical Director provided critical support for establishing key BH processes ~~of~~ monitoring utilization. Utilization triggers were developed to identify potential over utilization and to determine if the mild to moderate benefit was an appropriate level of care for the member. ~~of~~

~~monitoring utilization. Utilization triggers were developed to identify potential over utilization and to determine if the mild to moderate benefit was an appropriate level of care for the member.~~

C. UM Data Management

UM report design and generation is supported by CalOptima's Enterprise Analytics (EA) and Information Services (IS) department staff. Together with UM department subject matter experts, EA and IS maintained a focused effort to improve the understanding of key data standards to ensure reliable tracking and trending of metrics for both CalOptima and the delegated health networks. Further refinement of data (XML) file format ~~Decreased data lag was accomplished by implementation of a new (XML) file format~~ for health network submission of data elements including authorization information led to increased reliability of reports and improved the usefulness of information. Additional efforts are planned to leverage availability of this information to UM, Quality and Audit and Oversight (A&O) by configuring standard queries of the data mart.

~~In 2018, CalOptima migrated from MicroStrategy, a data analytics and visualization tool, to the Tableau platform which will enable advanced data analysis and reporting. The UM department also added a Data Analyst position that will assist in enhancing the quality of UM data and analysis.~~

D. UM Delegated Provider Oversight

~~D.~~ **Medi-Cal**

In 20182019, oversight of the delegated HNs for UM was performed by CalOptima's Audit and Oversight (A&O) department. Monthly, each HN was monitored by reviewing a sample of prior authorization referral files against the threshold of 98% for the following activities:

- Timeliness of decision and notification to the provider
- Clinical Decision Making, including application of medical necessity criteria and decision made by correct level of staff
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, preferred written language)

Timeliness:

The delegated HNs ~~performed~~ performance for timely decision making ranged from 88-99% for routine pre-service referrals and 86-99% for urgent pre-service referrals ~~well . for routine pre-service authorizations (98%). For expedited requests, the HNs, scoring 97%, had a negative variance to goal of 1%. One of the delegates encountered challenges in the first and second quarters with timeliness, but made marked improvement by the third and fourth quarters, following a corrective action plan~~ The established threshold for timeliness of clinical decision and notification is 98%. 90% of the health networks met threshold for routine pre-service referrals (10 of 11) and 81% (9 of 11) met the threshold for urgent pre-service referrals. CalOptima's A&O department issued corrective action plans (CAP) to the HNs for all performance less than the established threshold.

Clinical Decision Making

The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are approved, denied or modified. In 20182019, the HN files ranged between ~~67~~56–100% compliance with the standard for urgent files reviewed. For routine files reviewed, compliance ranged from 64-100% ~~, representing an opportunity for continued focus in this~~

~~area.~~. Audit and Oversight reviews files on a regular basis and initiates CAPs for performance less than the established threshold.

Notifications

The delegated HNs are audited regularly ~~on~~ for compliance with regulatory standards related ~~member~~to member notification~~s~~ of denials (NOAs). In ~~2018~~2019, compliance ~~to~~ with the standard ranged from ~~74–100%; this continues to be a focus for improvement.~~
64 -100% for urgent and 66-100% for routine HN referrals reviewed. Audit and Oversight reviews files on a regular basis and initiates CAPs for performance less than the established threshold.

~~2018~~2019 CalOptima Utilization Management Program- Evaluation

OCC

In ~~2018~~2019, oversight of the delegated HNs for UM was performed by CalOptima's A&O ~~Committee~~department to determine performance related to the threshold of 98%. On a quarterly basis, each of the delegates were monitored for the following activities by reviewing a sample of prior authorization referral files:

- Timeliness of decision and notification to the provider
- Clinical Decision Making, including application of medical necessity criteria and decision made by correct level of staff
- ~~Timeliness of decision and notification~~
- ~~Clinical Decision Making~~
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, preferred written language)

Timeliness

The delegated HNs range of performance for timely decision making ranged from 89% - 99% compliance, with 8/10 HNs meeting the threshold~~ed at **98%** compliance rate~~ for timeliness of decision and notification for routine pre-service authorizations. For expedited requests, the HNs performance ranged from 89-100%, with 9/10 HNs meeting the threshold~~, scoring **97%**, had a negative variance to goal of 1%.~~

Clinical Decision Making

The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are denied or modified. In ~~2018~~2019, the HN ~~files ranged~~performance ranged between ~~85 – 100~~56-100%, with 3/9 HNs reaching the threshold for routine requests and 0-100%, with 5/8 reaching threshold for urgent requests. This is an opportunity for improvement and the Audit and Oversight Department requires a corrective action plan for these health networks not meeting the regulatory requirement for clinical decision making ~~compliance with the standard representing an opportunity for continued focus in this area.~~.

Notifications

The delegated HNs are audited regularly on member notifications (NOA~~D~~s). In ~~2018~~2019, compliance to standard ranged from ~~53 – 100~~62-99%, with 2/9 reaching the threshold for routine notifications and 55-100%, with 3/9 HNs reaching the threshold for urgent notifications. ~~; t~~This continues to be a focus for improvement and corrective action plans have been issued by the Audit and Oversight Department to ensure that initiatives are put in place by the HSs to reach and maintain compliance.~~.~~

OC

In ~~2018~~2019, oversight of the delegated HNs for UM was performed by CalOptima's A&O ~~Committee~~department against the threshold of 98%. On a monthly basis, each of the delegates were monitored for the following activities by reviewing a sample of their prior authorization referral files:

- Timeliness of decision and notification to the provider
- Clinical Decision Making, including application of medical necessity criteria and decision made by correct level of staff

- ~~Timeliness of decision and notification~~
- ~~Clinical Decision Making~~
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, preferred written language)

Timeliness

The delegated HNs range of performance for clinical decision making~~performed at~~ ranged from ~~85~~71–100%, with 6/7 HNs meeting the threshold for routine referral timeliness and 43-100%, with 3/7 HNs meeting the threshold for urgent referral timeliness of ~~compliance rate for timeliness of~~ decision and notification~~ for routine pre-service authorizations. For expedited requests, the HNs, scoring **83–100%**, had opportunities for improvement~~. This is an area of continued focus and due to the low membership, one case out of compliance could put the HN below the compliance threshold. Audit and Oversight issues corrective action plans to ensure the HNs are putting initiatives in place to reach and maintain compliance with timeliness.

Clinical Decision Making

The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are approved, denied or modified. The ~~2018~~2019 HN performance ~~scores ranged from **72% (**~~53-100%, with 2/7 HNs meeting the threshold for routine referrals and 1 HN at 96% compliance for urgent. Again, due to the small membership in the OC product, one noncompliant case can render the HN below the threshold. Corrective action plans are issued by Audit and Oversight to ensure the HN meets and maintains compliance.~~**one outlier) to 100%.**~~

Notifications The delegated HNs are audited regularly on member notifications (NOA~~D~~s). In ~~2018~~2019, ~~compliance to standard ranged from~~performance ranged from 81~~-95-~~100%, with 4/7 meeting the threshold for routine cases and 81-100%, with 3/8 HNs meeting threshold for urgent cases~~representing significant improvement over 2017~~.

As with timeliness and clinical decision-making performance, Audit and Oversight issue corrective action plans to ensure initiatives are put in place by the HN to reach and maintain compliance.

Inpatient and Emergency Department (ED) Utilization Performance

Medi-Cal (MC) Shared Risk Average Length of Stay (ALOS): Trended downward in Q1-3 ~~2018~~2019 for Seniors and Persons with Disabilities (~~SPD)~~SPD). The trend for members in the Temporary Assistance for Needy Families (TANF) > 18 aid code ~~categaory~~category has shown an increase in ALOS for this population as compared to 2018 performance.~~and remained stable and at 3.0 or~~There was some fluctuation ~~below~~ for members in the aid category TANF ≤ 18.

- **Bed Days/Per Thousand Member Months Per Year (PTMPY):** ~~2018~~2019 goal was met for ~~SPD,~~ TANF ≤18 in ~~,~~Q1, but exceeded goal for the remaining quarters, attributed to the increased complexity of the population following WCM implementation in Q 3. TANF >18 attained goal for all quarters. SPD attained goal with the exception of Q1.~~178%.~~
- **Readmissions:** Stable Trend Q1-3; SPD average 23%, TANF > 18 average 17.3~~5.6~~%, TANF ~~≤~~ ~~<~~ 18 average ~~2.9~~3.1~~6~~%
- **ED Visits/PTMPY:**
  - **SPD:** goal was met in Q2~~1~~ and Q3~~2~~, goal exceeded by ~~10~~2% in Q1~~3~~
  - **TANF ≤ 18:** goal was exceeded in Q1 and Q2, but met goal in Q~~2018~~3
  - **TANF > 18:** goal was not met ~~in Q1 and Q3~~Q1-3 in 2019

Shared Risk – MC	Goal	Q1	Q2	Q3
SPD				
ALOS	-	5.3~~4.9~~	4.8~~4.4~~	4.8~~3.9~~
Bed Days/PTMPY	1120	1,215~~1,112~~	1,013~~942~~	1,004~~949~~
Readmissions	-	24%~~22%~~	24%~~24%~~	22%~~23%~~
ED Visits/PTMPY	700	714~~694~~	651~~689~~	666~~776~~
TANF >18				
ALOS	-	4.5~~4.4~~	4.3~~4.3~~	4.4~~3.8~~
Bed Days/PMPY	360	306~~294~~	285~~299~~	307~~314~~
Readmissions	-	17%~~17%~~	19%~~16%~~	16%~~14%~~
ED Visits/PTMPY	430	448~~441~~	469~~428~~	444~~479~~
TANF ≤18				
ALOS	-	2.9~~2.9~~	3.3~~2.8~~	3.2~~3.0~~
Bed Days/PTMPY	40	36~~48~~	41~~34~~	52~~40~~
Readmissions	-	6%~~2%~~	4%~~4%~~	8%~~1%~~

ED Visits/PTMPY	310	379~~426~~	324~~313~~	300~~331~~

Medi-Cal CCN

- **Average Length of Stay**
  - **SPD:** Stable trend and remained relatively flat for Q1 – 3 2019.~~with slight spike to 5.3 in Q2~~
  - **TANF > 18:** Slow decline in ALOS noted quarter-over-quarter.~~Stable trend with average at 4.3 days~~
  - **TANF ≤ 18:** Q2 trended down for Q2, however, Q3 more than doubled from Q2 which may reflect the implementation of WCM July 1, 2019.~~goal was not met in 2018 but trended down in Q1-3~~
- **Bed Days/PTMPY:** ~~2018~~2019 Bed Days goals were met for ~~each of the subpopulations~~both TANF populations; SPD bed days increased during Q2 and then slight decrease in Q3, but both quarters were above goal. There are many variables that could impact the increased bed days for these quarters, however, the decrease from Q2 to Q3 may be due to special cause variation that has not been determined at this time.
- **Readmissions:** ~~Stable Trend Q1-3; SPD average 24%, TANF > 18 average 21%, TANF < 18 average 2%~~SPD readmissions increased by 1 percentage point quarter-over-quarter. Readmission increase from Q 1– to Q2 for TANF > 18, but Q3 dropped below Q1 rate. TANF ≤18 increased Q1, which may be related to the flu season, dropped for Q2 and then shot up Q3 most likely due to the WCM implementation July 1, 2019.
- **ED Visits/PTMPY**
  - **SPD:** goal was not met in ~~2018~~2019
  - **TANF > 18:** goal was not met in ~~2018~~2019
  - **TANF ≤ 18:** goal was not met in Q1 ~~2018~~2019; ~~not~~ met in Q2 and Q3

CCN	Goals	Q1	Q2	Q3
SPD				
ALOS	~~--~~	5.1~~5.14~~.4	5.1~~5.15~~.3	5.0~~5.04.6~~
Bed Days/PTMPY	1830~~1830~~~~1830~~	1,773~~1,773~~~~1,679~~	1,917~~1,917~~~~1,763~~	1,875~~1,875~~~~1,784~~
Readmissions	~~--~~	31%~~31%~~~~25%~~	32%~~32%~~~~25%~~	33%~~33%~~~~23%~~
ED Visits/PTMPY	640~~640~~~~640~~	940~~940~~~~932~~	967~~967~~~~891~~	903~~903~~~~1,027~~
TANF >18				
ALOS	~~--~~	5.3~~5.34~~.5	5.1~~5.14~~.3	5.0~~5.04.0~~
Bed Days/PMPY	710~~710~~~~710~~	577~~577~~~~465~~	529~~529~~~~472~~	515~~515~~~~458~~
Readmissions	~~--~~	27%~~27%~~~~22%~~	30%~~30%~~~~22%~~	26%~~26%~~~~18%~~

ED Visits/PTMPY TANF≤18	490490~~490~~	630630 ~~622~~	649649 ~~623~~	612612~~685~~
ALOS	--	3.03.04 ~~.0~~	2.22.22 ~~.2~~	4.94.92~~.2~~
Bed Days/PTMPY	100100~~100~~	515165~~65~~	292928~~28~~	797932~~32~~
Readmissions	--	6%6%~~6~~ ~~%~~	3%3%~~0~~ ~~%~~	7%7%~~0%~~
ED Visits/PTMPY	470470~~470~~	497497 ~~545~~	388388 ~~419~~	381381~~429~~

~~2018~~2019 CalOptima Utilization Management Program~~-~~ Evaluation

~~The~~ **CalOptima Direct Administrative** (CODA) ~~2018~~2019 Bed Day and ED visit goals for the year were met for SPD~~;~~ TANF > 18 bed days were above goal for Q2 and 3 and below goal for ED visits ~~except for the first quarter for TANF members ≤18 for Bed Days and ED visits were slightly above goal in Q1~~. TANF ≤ 18 bed days were above goal for Q 1 and Q3, but below goal for Q2. The spike in bed days for Q3 are attributable to the WCM implementation July 1, 2019. ED visits were below goal for all 3 Quarters. The low values are attributable to a smaller population for the CODA.

COD	Goals	Q1	Q2	Q3
SPD				
ALOS	~~-~~	5.7~~5.7~~~~5.3~~	5.9~~5.9~~~~5~~ ~~.4~~	5.7~~5.7~~~~4.9~~
Bed Days/PTMPY	1920~~1920~~~~1920~~	821~~821~~~~926~~	843~~843~~ ~~856~~	930~~930~~~~65~~ ~~7~~
Readmissions	~~-~~	4%~~4%~~~~3%~~	4%~~4%~~~~3~~ ~~%~~	4%~~4%~~~~2%~~
ED Visits/PTMPY	1120~~1120~~~~1120~~	2~~2~~~~74~~	5~~5~~~~76~~	7~~7~~~~75~~
TANF >18				
ALOS	~~-~~	5.6~~5.6~~~~4.7~~	6.1~~6.1~~~~5~~ ~~.1~~	6.1~~6.1~~~~4.2~~
Bed Days/PMPY	600~~600~~~~600~~	462~~462~~~~362~~	617~~617~~ ~~447~~	699~~699~~~~37~~ ~~4~~
Readmissions	~~-~~	9%~~9%~~~~17%~~	13%~~13~~ ~~%~~~~16%~~	11%~~11%~~~~1~~ ~~0%~~
ED Visits/PTMPY	580~~580~~~~580~~	15~~15~~~~384~~	14~~14~~~~42~~ ~~9~~	45~~45~~~~449~~
TANF≤18				
ALOS	~~-~~	3.1~~3.1~~~~3.0~~	2.9~~2.9~~~~3~~ ~~.7~~	13.1~~13.1~~~~3.2~~
Bed Days/PTMPY	75~~75~~~~75~~	101~~101~~~~84~~	75~~75~~~~4~~ ~~9~~	625~~625~~~~45~~
Readmissions	~~-~~	3%~~3%~~~~3%~~	4%~~4%~~~~0~~ ~~%~~	1%~~1%~~~~0%~~
ED Visits/PTMPY	400~~400~~~~400~~	2~~2~~~~418~~	0~~0~~~~314~~	0~~0~~~~295~~

One~~-~~Care Connect Shared Risk results show progressive improvement in both Bed Days and ED Visits over the course of the year, apart from the third quarter for members in the TANF group. The low values for TANF > 18 bed days and readmissions are noted and warrant additional analyses to be reported at the UMC in 2020, with the appropriate interventions to improve performance as warranted.

~~This may be due to the virulent flu season in 2018.~~

Shared Risk - OCC	Goals	Q1	Q2	Q3
SPD				
ALOS	~~-~~	5.1~~5.1~~~~4.5~~	4.7~~4.7~~~~5.0~~	4.9~~4.9~~~~4.5~~
Bed Days/PTMPY	1340~~134~~ ~~0~~~~1340~~	1,202~~1~~ ~~,202~~~~85~~ ~~2~~	1,018~~1,0~~ ~~18~~~~1,065~~	1,016~~1~~ ~~,016~~~~91~~ ~~2~~
Readmissions	~~-~~	20%~~20~~ ~~%~~~~19%~~	20%~~20%~~ ~~20%~~	20%~~20~~ ~~%~~~~17%~~
ED Visits/PTMPY	410~~410~~~~410~~	432~~432~~ ~~385~~	414~~414~~~~422~~	397~~39~~ ~~7~~~~432~~
TANF>18				
ALOS	~~-~~	6.5~~6.5~~~~3.8~~	0.0~~0.0~~~~4.9~~	7.5~~7.5~~~~4.5~~
Bed Days/PTMPY	~~-~~	1,106~~1~~ ~~,106~~~~59~~ ~~4~~	0~~0~~~~1,012~~	1,094~~1~~ ~~,094~~~~87~~ ~~3~~
Readmissions	~~-~~	0%~~0%~~~~5%~~	0%~~0%~~~~11~~ ~~%~~	0%~~0%~~ ~~10%~~
ED Visits/PTMPY	~~-~~	471~~471~~ ~~509~~	537~~537~~~~481~~	448~~44~~ ~~8~~~~493~~

NOTE: No Established Goal for OCC Shared Risk TANF > 18

~~2018~~2019 CalOptima Utilization Management Program~~-~~ Evaluation

OCC CCN demonstrated improvement in bed day utilization in ~~2018~~2019, though ED usage was higher than anticipated, especially during Q2 for the TNF > 18 population and this same population with a sharp decline in Q3. ~~2018 OCC CCN Data will be reviewed in 2019, and additional interventions may be applied as needed.~~These trends warrant additional analyses to be reported at the UMC in 2020, with the appropriate interventions to improve performance as warranted.

CCN - OCC	Goals	Q1	Q2	Q3
SPD				
ALOS	~~-~~	5.6~~5.6~~5~~.2~~	6.5~~6.5~~4~~.4~~	5.3~~5.3~~5.3
Bed Days/PTMPY	1980~~1980~~1980	1,442~~1,4~~ ~~42~~1,573	1,729~~1,7~~ ~~29~~1,138	1,672~~1,672~~ ~~1,064~~
Readmissions	~~-~~	22%~~22%~~ ~~14%~~	33%~~33%~~ ~~22%~~	26%~~26%~~1 ~~1%~~
ED Visits/PTMPY	410~~410~~410	627~~627~~ ~~609~~	587~~587~~ ~~600~~	635~~635~~680
TANF>18				
ALOS	~~-~~	5.1~~5.1~~3~~.8~~	4.1~~4.1~~6~~.1~~	1.0~~1.0~~3.7
Bed Days/PTMPY	~~-~~	1,197~~1,1~~ ~~97~~1,437	1,668~~1,6~~ ~~68~~1,919	8686975
Readmissions	~~-~~	0%~~0%~~24 ~~%~~	0%~~0%~~18 ~~%~~	0%~~0%~~ ~~19%~~
ED Visits/PTMPY	~~-~~	350~~350~~ ~~594~~	1,661~~1,~~ ~~661~~697	594~~594~~1,0 ~~82~~

OC results were variable, likely related to the small population size, but did show improvement in bed day utilization for the first three quarters

OC	Goals	Q1	Q2	Q3
ALOS	~~-~~	5.1~~5.1~~6.3	5.2~~5.2~~5.1	4.0~~4.0~~ ~~4.1~~
Bed Days/PTMPY	1370~~137~~ ~~0~~1370	1,100~~1,1~~ ~~00~~1,238	787~~78~~ ~~7~~857	508~~50~~ ~~8~~642
Readmissions	~~-~~	10%~~10%~~ ~~20%~~	19%~~19~~ ~~%~~12%	11%~~11%~~ ~~4%~~
ED Visits/PTMPY	480~~480~~480	509~~509~~420	393~~39~~ ~~3~~419	431~~43~~ ~~1~~439

Over and Underutilization is monitored, tracked, managed and reported by ~~Quality Analytics, Quality Improvement,~~ UM ~~and Case Management~~during 2019 and reported to ~~QIC, UMC, and QAC by product at least quarterly in 2018~~UMC, QIC and the Quality Assurance Committee (QAC). ~~Data analysis reveals 2018 ED utilization that exceeds goals and will continue to be evaluated and considered as care is planned and coordinated for CalOptima members.~~

The data do not reveal any significant variation in data warranting immediate intervention, however, a robust organization-wide over and underutilization monitoring process will be developed and reported to the appropriate committees during 2020.

III Operational Performance

A. Authorization for Expedited / Urgent, Standard / Routine, Retrospective Requests ~~–~~ – Medical ~~A.~~ (This includes inpatient, outpatient and physician services).

~~2018~~2019 - Summary of referral volume (Quarter 1Quarter 3)

Referrals Processed		Referrals Received		Turnaround Time Compliancy (TAT)	
Routine:~~Rou~~	**123,729~~150,4~~**	Faxed:		Routine	**99.95%**
Urgent:~~Urge~~	**15,283~~16,80~~**	COLAS:		Urgent	**99.45%**
Retro:~~Retro:~~	**7,539~~7,643~~**	~~Total:~~	~~**175,314**~~	Retro TAT:~~Retro~~	**99.76%**
Total:~~Total:~~	**146,551*~~174,~~**	**Total:**	**190,666**		

Total volume of referrals increased from 2018 by 28,391 or 16.2% ~~2017 by 48,335 or 38.2%~~ Volume of faxed referrals increased from 2018 by 12,050 or 13.3%~~2017 by 28,947 or 58.9%~~

Volume of portal (COLA) referrals increased from 2018 by 3,302 or 3.2% ~~2017 by 17,590 or 22.1%~~

*The difference between referrals received and processed may be attributed to duplicate submissions and/or requests that do not require authorization.

Online Referral Rate Submission

Online referral submission ~~rate over~~increased over the 3 quarters ~~was 55%~~by 11 ~~in~~% in ~~2018~~2019. In 2018, Q1-Q3, there were 91,334 online referrals and during the same period of 2019, there were 100,542.
~~and was 63% over 4 quarters of 2017.~~

Referral TAT was compliant for all referral types in the first 3 quarters of ~~2018~~2019.

B. Authorization for Expedited / Urgent / Routine / Retro Requests – Pharmacy

~~2018~~2019 CalOptima Utilization Management Program- Evaluation

Annual summary of turnaround time compliance, through 3Q19:~~2018~~:

OC: ~~100~~100%

OCC: 99.~~7~~7%

Medi-Cal: 98.8%

Pharmacy Prior Authorization TAT processing time are above the goal of 9~~8~~7% for ~~OC and OCC~~all plans. ~~The TAT for Medi-Cal fell below goal in 2Q17 due to a change in the PBM PA system.~~ Pharmacy metric targets were achieved for ~~2018~~2019.

C. Authorization for Expedited / Urgent / Routine / Retro Requests – LTSS (CBAS, LTC)

- LTSS consistently met required turnaround times throughout the year. LTSS metric targets were achieved for ~~2018~~2019 (Q1-3):
  - CBAS CEDT: 100%
  - CBAS Routine: ~~99~~100%
  - CBAS Expedited: None received
    - Members participating in CBAS Q1-Q3 2019: Potentially program-eligible members

      QTR 1:
      OCC: 180/14,186 (1.27%) = Increase
      Medi-Cal: 2,457/111,227 (2.21%) = No Change

      QTR 2:
      OCC: 193/14,213 (1.36%) = Increase
      Medi-Cal: 2,500/114,939 (2.18%) = Decrease

      QTR 3:
      OCC: 205/14,171 (1.45%) = increase
      Medi-Cal: 2,568/101,012 (2.54%) = increase
    - 80% of authorized CBAS participation days will be utilized/delivered (Q1-Q3 2019).

      QTR 1:
      101,754 Days Used of 128,785 Authorized (79.01%)

      QTR 2:
      107,281 Days Used of 133,148 Authorized (80.57%)

      QTR 3:
      107,281 Days Used of 133,148 Authorized (80.57%)
    - ~~o~~ Goal Met: Continue to monitor
  - LTC Routine: ~~100~~98.99%
  - LTC Urgent: None received
  - MSSP Discharges will not exceed New Admissions by more than 2 members during the quarter.

    QTR 1:
    OCC: 180/14,186 (1.27%) = Increase
    Medi-Cal: 2,457/111,227 (2.21%) = No Change

    QTR 2:
    OCC: 193/14,213 (1.36%) = Increase
    Medi-Cal: 2,500/114,939 (2.18%) = Decrease

QTR 3:
OCC: 205/14,171 (1.45%) = increase
Medi-Cal: 2,568/101,012 (2.54%) = increase

MSSP Goal met. Continue with this goal.

D. Inter-Rater Reliability (Physicians, Nurses, Pharmacy) pertains to agency quality review of UM, CBAS, MSSP, LTC by annual assessment of appropriate guideline application.

The IRR was administered in compliance with the UM Program. IRR metric targets were achieved for ~~2018~~2019. All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

UM Clinical Staff:
Prior Authorization: 90%
Concurrent Review: 90%
Physicians: 97%
Pharmacy: 100%
LTSS: LTC tested on Q3 for an average of 95.7%, CBAS tested in Q3 for an average of 96.6% and MSSP did not test in 2019~~95%~~

E. Denial (Letter) Process

Performance has continued to improve throughout ~~2018~~2019. A specific area of focus was the appropriate lay language, which has demonstrated significant improvement, though there remains some variability across the HNs. A workgroup begun in ~~2018~~2019 consisting of participants from CalOptima UM, BHI, Pharmacy, GARS and A&O that will continue to identify and share best practices to attain further improvement in this area. NCQA ~~2018~~2019 Survey demonstrated full compliance with the denial process across CCN and the HNs selected for review.

III. Utilization Performance / Outcomes

A. Facility Utilization – Facility Acute and Emergency Care

Analysis of inpatient and ED data in ~~2018~~2019 identified positive performance against goals in Bed Days/PTMPY, however, the emergency department utilization was variable, and overall, higher than ~~anticipated.~~established goals for this metric, as evidenced on the preceding Inpatient and Emergency Department Utilization Performance tables.

Review of ~~2018~~2019 ED Data will be conducted, and additional interventions may be applied as needed.

LTSS Program Members admitted to LTC NF Q1-Q3 2019: A total of 21 CBAS were admitted to an LTC for the first 3 quarters of 2019.

CBAS: Track CBAS participants who transition to LTC. Goal: To be determined after establishing baseline.

QTR 1:
Medi-Cal: 5/2,457 (0.20%)
OCC: 1/180 (0.55%)

QTR 2:
Medi-Cal: 8/2,500 (0.32%)
OCC: 0/193 (0.0%)

QTR 3:
Medi-Cal: 6/2,568 (0.23%)
OCC: 1/205 (0.49%)

LTC: Members residing in LTC:

QTR 1:
OCC: 220/14,186 (1.55%) = decrease
SPD: 5,098/111,227 (4.58%) = Increase

QTR 2:
OCC: 200/14,213 (1.41%) = decrease
SPD: 5,101/114,939 (4.44%) = Decrease

QTR 3:
OCC: 196/14,171 (1.38%) = decrease
Medi-Cal: 5,130/101,012 (5.26%) = increase

B. Pharmacy Utilization

Outpatient pharmacy utilization increases in 2019 are primarily driven by increased utilization of diabetes medications and seasonal increases in analgesics and antibiotics during the cold and flu season.

Opioid analgesic utilization (average morphine milligram equivalent) has decreased 17.6% from 3Q18 to 3Q19.

- ~~Retail Pharmacy: $PMPM costs for all LOB are below goal~~
- ~~Diabetes drug utilization is the second highest drug class by cost for OCC and highest for Medi-Cal. Opioid analgesic utilization has decreased 8.5% from 3Q17 to 3Q18. Medi-Cal: Goal $ PMPM $54.13, actual CY18 through 3Q18 $52.60 OC: Goal $ PMPM $354.63, actual CY18 through 3Q18 $337.30 OCC: Goal $ PMPM $380.33, actual CY18 through 3Q18 $373.40~~

C. Member and Provider Satisfaction

Member and Provider Satisfaction with the UM Program is important to CalOptima. The following approaches are incorporated into the UM Program to promote continuous improvement in this area:

- Providing information to members and providers about the UM Program
  - Members are informed about authorization requirements through the Member Handbook and member newsletters
  - New member orientation is available for all CalOptima members to better understand their benefits
  - Access to a list of services requiring pre-authorization is also available on CalOptima's website
  - CalOptima Customer Service and clinical staff are available to assist member's in accessing services, as needed
  - Providers receive on-site visits from CalOptima's Provider Relations team, who provide tools and references for requesting authorizations for their members
  - A Provider Toolkit is available on the CalOptima website for provider reference
  - CalOptima Link provides an easily accessed electronic means of requesting authorizations for providers
- Ensuring timeliness and notification of UM decisions
  - Monitored and reported quarterly to UMC: In ~~2018~~2019, the percent of authorization requests completed in a timely manner overall exceeded 97.5%
- Consistent use of approved, evidence-based guidelines in clinical decision making
  - Monitored monthly by the A&O Committee
  - Variation among the delegated HNs
  - Additional training provided as needed
  - Overall improvement in audit scores for clinical decision making in ~~2018~~2019

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals related to the UM Program. In ~~2018~~2019, complaints about the UM Program demonstrated some trends in the following categories:

- Member concerns:
  - Pharmacy Home Program and quantity limits on opioid medications
  - Quality of service by pain management practitioners
  - Supplemental dental benefits

  - There was a significant decrease in the number of complaints about transportation by OC and OCC members. This is clearly due to the new Medi-Cal non-medical transportation benefit, which became effective in July ~~2018~~2019

- Provider concerns:
  - Redirection from tertiary level of care for non-complex condition management
  - Level of payment disputes, especially from non-participating and/or out of area providers

While member concerns regarding the Pharmacy Home Program and quantity limits on opioid medications have risen, these controls remain as efforts to impact the strengthening opioid crisis. Provider, member and community education on the cautious and appropriate use of these medications will promote understanding of these programs. Complaints about pain management practitioners is likely a related issue. However, oversight of these providers and prompt review of any quality concerns will continue; appropriate peer review activities are performed by the Credentialing and Peer Review Committee.

CalOptima has worked closely with Liberty Dental to address complaints regarding supplemental dental benefits and recent updates to the contract should improve member experience. OCC and OC members will not have the option to select Liberty dental in 2019. The only dental benefits they have is Denti-Cal, which they will be referred to.

Provider disputes regarding redirection from tertiary level of care have begun to trend downward as CalOptima has strengthened the regular communication with UCI Medical Center through quarterly joint operations meetings. Education continues with out of area and out of network providers regarding appropriate billing practices, especially for Medi-Medi members.

IV Summary

In ~~2018~~2019, CalOptima made progress improving the effectiveness of the UM program and decreasing administrative barriers. We also brought on a pool of expertise to enhance our programs, including a pediatric physician with CCS expertise to assist with WCM. Major initiatives included improvements to CalOptima's medical management system and network data interfaces as well as continued focus on Compliance, maintenance of current policies and procedures, report development, preparation for the Whole-Child Model transition leveraging existing processes and model(s) of care.

The UMC and the UM Medical Director continue to guide and support CalOptima UM programs, as well as the Deputy CMO position which was resurrected and filled during 2019. New management staff were brought on during Q3 of 2019, which includes a UM Director and PA Manager. Our overall referral volume increased during 2019, however, compliance with regulatory standards remained strong for CCN/COD. Deficiencies in HN performance as noted in the preceding "UM Delegated Provider Oversight" section were identified by the Audit and Oversight team and CAPs were issued.

2019 CalOptima Utilization Management Program Evaluation

Executive Summary

The 2019 Utilization Management (UM) Program describes CalOptima's activities to promote optimum utilization of health care services for our members delivered in a high-quality, compassionate and cost-effective manner.

This evaluation of UM activity is completed annually and approved by the Utilization Management Committee (UMC), the Quality Improvement Committee (QIC), the Quality Assurance Committee (QAC) and CalOptima's Board of Directors.

There have been no changes to the overall UM program structure elements listed below during 2019. The program structure elements are:

- UM staff assigned activities;
- UM staff who have the authority to deny coverage;
- Involvement of a designated physician and a designated behavioral healthcare practitioner;
- The process for evaluating, approving and revising the UM program, and those responsible for each step;
- The UM program's role in the QI program, including how the organization collects UM information and uses it for QI activities; and
- The process for handling appeals and making appeal determinations.

Projects, Programs and Initiatives:

A. Utilization Management

In 2019, the UM department initiated several projects to support improved efficiency, decreased administrative burden and improved quality of provider and member facing documentation. These projects included:

- Upgrades/enhancements to the Guiding Care (GC) Utilization Review Module in CalOptima's medical management system
- Desktop Procedures – cataloged, reviewed and updated
- Continued development of CalOptima Reporting Environment (CORE) to align operational reports with the data structure in GC and to continue to identify opportunities for process improvement
- Successful transition on July 1, 2019 of CalOptima members eligible with the California Children's Services Program (CCS) to the Whole Child Model (WCM) Program.

- Ensured all policies and procedures were in effect in accordance with regulatory requirements and accurately represent clinical operations processes.

The Medical Director of UM provides clinical oversight for the administration of the UM Program and has been very engaged during 2019. He/she supports the UM process by ensuring that treatment requests are processed in accordance with regulatory, contractual and accreditation guidelines and clinical evidence-based criteria, and by evaluating the program's effectiveness against established goals. For UM Program areas that do not meet the approved goals, modifications to program activities are proposed by leadership to the UM Workgroup (UMWG). As endorsed by the UMWG, the updated plan is presented and approved by the Utilization Management Committee (UMC). These changes are implemented by the UM Leadership and department staff. The UM Medical Director supports provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee (BMSC). This subcommittee evaluates new and modified benefits to determine the need for prior authorization. He/she also chairs the bi-weekly UMWG, which provides input to the development and processes of UM Program to ensure quality, cost efficient services and care are delivered to CalOptima members. The UM Medical Director led discussions with the nursing and physician group in semiweekly concurrent review case rounds, discussing appropriate care guidelines, clinical and practical aspects of managing medically complex members in the acute and post-acute care settings and assisting with discharge planning management. He also provided education to the team to ensure understanding of the clinical basis for decisions..

The UM Medical Director also provided focused education on specific topics including: genetic testing, transgender procedures, management of administrative days, appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria, the Letter of Agreement (LOA) process, and evaluation of the appropriateness of one-day inpatient stays.

In 2019, the UM Medical Director adequately supported the UM process and met the needs of the UM team through education, case review and availability.

B. Behavioral Health Integration

In 2019, CalOptima continued to manage all the administrative functions of Medi-Cal mild to moderate mental health benefits and behavioral health treatment (BHT) services for CalOptima members, including UM, claims, provider network, credentialing, member services, care coordination, and Quality Improvement (QI. The Behavioral Health Integration (BHI) department worked closely with other departments to ensure the provision of treatment was in accordance with mental health parity legislation and the prior authorization process complied with all federal, state, contractual, regulatory and accreditation guidelines.

For OneCare (OC) and OneCare Connect (OCC), Magellan Health served as CalOptima's Managed Behavioral Health Organization (MBHO) with the full spectrum of administrative responsibilities including UM, provider network, credentialing, customer service, inpatient services, and care coordination. BHI maintained a close working relationship with Health Network (HN) management providing oversight of the MBHO's delivery of the mental health services and administrative functions.

The Behavioral Health Quality Improvement (BHQI) Subcommittee was held on a quarterly basis and reported to the Quality Improvement Committee (QIC). The BHQI trends, analyzes and identifies improvement areas for behavioral health (BH) services, ensures access to quality BH care, and enhances continuity and coordination between behavioral health and physical health care providers The BHQI is chaired by the BH Medical Director and is comprised of internal and external members, which include delegated health network participants, community partners, behavioral health practitioners, and the Orange County Mental Health Plan (MHP), administered by the Orange County Health Care Agency (OC HCA). The chair is responsible for leading and presenting subcommittee recommendations to the QIC. In addition, a BHQI workgroup met regularly throughout 2019 for additional work and analysis on BH quality initiatives. This group served to address suggestions from the BHQI that assisted with strengthening interventions, data review and key areas for improving the member experience. In 2019, the BH Medical Director provided critical support for establishing key BH processes of monitoring utilization. Utilization triggers were developed to identify potential over utilization and to determine if the mild to moderate benefit was an appropriate level of care for the member.

C. UM Data Management

UM report design and generation is supported by CalOptima's Enterprise Analytics (EA) and Information Services (IS) department staff. Together with UM department subject matter experts, EA and IS maintained a focused effort to improve the understanding of key data standards to ensure reliable tracking and trending of metrics for both CalOptima and the delegated health networks. Further refinement of data (XML) file format f o r health network submission of data elements including authorization information led to increased reliability of reports and improved the usefulness of information.. Additional efforts are planned to leverage availability of this information to UM, Quality and Audit and Oversight (A&O) by configuring standard queries of the data mart.

D. UM Delegated Provider Oversight

Medi-Cal

In 2019, oversight of the delegated HNs for UM was performed by CalOptima's Audit and Oversight (A&O) department. Monthly, each HN was monitored by reviewing a sample of prior authorization referral files against the threshold of 98% for the following activities:

- Timeliness of decision and notification to the provider
- Clinical Decision Making, including application of medical necessity criteria and decision made by correct level of staff
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, preferred written language)

Timeliness:

The delegated HNs performance for timely decision making ranged from 88-99% for routine pre-service referrals and 86-99% for urgent pre-service referrals. The established threshold for timeliness of clinical decision and notification is 98%. 90% of the health networks met threshold for routine pre-service referrals (10 of 11) and 81% (9 of 11) met the threshold for urgent pre-service referrals.

CalOptima's A&O department issued corrective action plans (CAP) to the HNs for all performance less than the established threshold.

Clinical Decision Making
The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are approved, denied or modified. In 2019, the HN files ranged between 56–100% compliance with the standard for urgent files reviewed. For routine files reviewed, compliance ranged from 64-100%. Audit and Oversight reviews files on a regular basis and initiates CAPs for performance less than the established threshold.

Notifications
The delegated HNs are audited regularly for compliance with regulatory standards related to member notification of denials (NOAs). In 2019, compliance with the standard ranged from 64 -100% for urgent and 66-100% for routine HN referrals reviewed. Audit and Oversight reviews files on a regular basis and initiates CAPs for performance less than the established threshold.

OCC
In 2019, oversight of the delegated HNs for UM was performed by CalOptima's A&O department to determine performance related to the threshold of 98%. On a quarterly basis, each of the delegates were monitored for the following activities by reviewing a sample of prior authorization referral files:

- Timeliness of decision and notification to the provider
- Clinical Decision Making, including application of medical necessity criteria and decision made by correct level of staff
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, preferred written language)

Timeliness
The delegated HNs range of performance for timely decision making ranged from 89% - 99% compliance, with 8/10 HNs meeting the threshold for timeliness of decision and notification for routine pre-service authorizations. For expedited requests, the HNs performance ranged from 89-100%, with 9/10 HNs meeting the threshold

Clinical Decision Making
The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are denied or modified. In 2019, the HN performance ranged between 56-100%, with 3/9 HNs reaching the threshold for routine requests and 0-100%, with 5/8 reaching threshold for urgent requests. This is an opportunity for improvement and the Audit and Oversight Department requires a corrective action plan for these health networks not meeting the regulatory requirement for clinical decision making.

Notifications
The delegated HNs are audited regularly on member notifications (NOAs). In 2019, compliance to standard ranged from 62-99%, with 2/9 reaching the threshold for routine notifications and 55-100%, with 3/9 HNs reaching the threshold for urgent notifications. This continues to be a focus for improvement and corrective action plans have been issued by the Audit and Oversight Department to ensure that initiatives are put in place by the HSs to reach and maintain compliance.

OC

In 2019, oversight of the delegated HNs for UM was performed by CalOptima's A&O department against the threshold of 98%. On a monthly basis, each of the delegates were monitored for the following activities by reviewing a sample of their prior authorization referral files:

- Timeliness of decision and notification to the provider
- Clinical Decision Making, including application of medical necessity criteria and decision made by correct level of staff
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, preferred written language)

Timeliness

The delegated HNs range of performance for clinical decision making ranged from 71–100%, with 6/7 HNs meeting the threshold for routine referral timeliness and 43-100%, with 3/7 HNs meeting the threshold for urgent referral timeliness of decision and notification. This is an area of continued focus and due to the low membership, one case out of compliance could put the HN below the compliance threshold. Audit and Oversight issues corrective action plans to ensure the HNs are putting initiatives in place to reach and maintain compliance with timeliness.

Clinical Decision Making

The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are approved, denied or modified. The 2019 HN performance ranged from 53-100%, with 2/7 HNs meeting the threshold for routine referrals and 1 HN at 96% compliance for urgent. Again, due to the small membership in the OC product, one noncompliant case can render the HN below the threshold. Corrective action plans are issued by Audit and Oversight to ensure the HN meets and maintains compliance.

Notifications The delegated HNs are audited regularly on member notifications (NOAs). In 2019, performance ranged from 81-100%, with 4/7 meeting the threshold for routine cases and 81-100%, with 3/8 HNs meeting threshold for urgent cases.

As with timeliness and clinical decision-making performance, Audit and Oversight issue corrective action plans to ensure initiatives are put in place by the HN to reach and maintain compliance.

Inpatient and Emergency Department (ED) Utilization Performance

Medi-Cal (MC) Shared Risk

- **Average Length of Stay (ALOS):** Trended downward in Q1-3 2019 for Seniors and Persons with Disabilities (SPD). The trend for members in the Temporary Assistance for Needy Families (TANF) > 18 aid code category has shown an increase in ALOS as compared to 2018 performance. There was some fluctuation for members in the aid category TANF ≤ 18.
- **Bed Days/Per Thousand Member Months Per Year (PTMPY):** 2019 goal was met for TANF ≤18 in Q1, but exceeded goal for the remaining quarters, attributed to the increased complexity of the population following WCM implementation in Q 3. TANF >18 attained goal for all quarters. SPD attained goal with the exception of Q1.
- **Readmissions:** Stable Trend Q1-3; SPD average 23%, TANF > 18 average 17.3%, TANF ≤ 18 average 6%
- **ED Visits/PTMPY:**
  - **SPD:** goal was met in Q2 and Q3, goal exceeded by 2% in Q1
  - **TANF ≤ 18:** goal was exceeded in Q1 and Q2, but met goal in Q3
  - **TANF > 18:** goal was not met Q1-3 in 2019

Shared Risk – MC	Goal	Q1	Q2	Q3
SPD				
ALOS	-	5.3	4.8	4.8
Bed Days/PTMPY	1120	1,215	1,013	1,004
Readmissions	-	24%	24%	22%
ED Visits/PTMPY	700	714	651	666
TANF >18				
ALOS	-	4.5	4.3	4.4
Bed Days/PMPY	360	306	285	307
Readmissions	-	17%	19%	16%
ED Visits/PTMPY	430	448	469	444
TANF ≤18				
ALOS	-	2.9	3.3	3.2
Bed Days/PTMPY	40	36	41	52
Readmissions	-	6%	4%	8%

ED Visits/PTMPY	310	379	324	300

Medi-Cal CCN

- **Average Length of Stay**
  - **SPD:** Stable trend and remained relatively flat for Q1 – 3 2019.
  - **TANF > 18:** Slow decline in ALOS noted quarter-over-quarter.
  - **TANF ≤ 18:** Q2 trended down for Q2, however, Q3 more than doubled from Q2 which may reflect the implementation of WCM July 1, 2019.
- **Bed Days/PTMPY:** 2019 Bed Days goals were met for both TANF populations; SPD bed days increased during Q2 and then slight decrease in Q3, but both quarters were above goal. There are many variables that could impact the increased bed days for these quarters, however, the decrease from Q2 to Q3 may be due to special cause variation that has not been determined at this time.
- **Readmissions:** SPD readmissions increased by 1 percentage point quarter-over-quarter. Readmission increase from Q 1– to Q2 for TANF > 18, but Q3 dropped below Q1 rate. TANF ≤18 increased Q1, which may be related to the flu season, dropped for Q2 and then shot up Q3 most likely due to the WCM implementation July 1, 2019.
- **ED Visits/PTMPY**
  - **SPD:** goal was not met in 2019
  - **TANF > 18:** goal was not met in 2019
  - **TANF ≤ 18:** goal was not met in Q1 2019; met in Q2 and Q3

CCN	Goals	Q1	Q2	Q3
SPD				
ALOS	-	5.1	5.1	5.0
Bed Days/PTMPY	1830	1,773	1,917	1,875
Readmissions	-	31%	32%	33%
ED Visits/PTMPY	640	940	967	903
TANF >18				
ALOS	-	5.3	5.1	5.0
Bed Days/PMPY	710	577	529	515
Readmissions	-	27%	30%	26%
ED Visits/PTMPY	490	630	649	612
TANF≤18				

ALOS	-	3.0	2.2	4.9
Bed Days/PTMPY	100	51	29	79
Readmissions	-	6%	3%	7%
ED Visits/PTMPY	470	497	388	381

CalOptima Direct Administrative (CODA) 2019 Bed Day and ED visit goals for the year were met for SPD; TANF > 18 bed days were above goal for Q2 and 3 and below goal for ED visits. TANF ≤ 18 bed days were above goal for Q 1 and Q3, but below goal for Q2. The spike in bed days for Q3 are attributable to the WCM implementation July 1, 2019. ED visits were below goal for all 3 Quarters. The low values are attributable to a smaller population for the CODA.

COD	Goals	Q1	Q2	Q3
SPD				
ALOS	-	5.7	5.9	5.7
Bed Days/PTMPY	1920	821	843	930
Readmissions	-	4%	4%	4%
ED Visits/PTMPY	1120	2	5	7
TANF >18				
ALOS	-	5.6	6.1	6.1
Bed Days/PMPY	600	462	617	699
Readmissions	-	9%	13%	11%
ED Visits/PTMPY	580	15	14	45
TANF≤18				
ALOS	-	3.1	2.9	13.1
Bed Days/PTMPY	75	101	75	625
Readmissions	-	3%	4%	1%
ED Visits/PTMPY	400	2	0	0

OneCare Connect Shared Risk results show progressive improvement in both Bed Days and ED Visits over the course of the year, apart from the third quarter for members in the TANF group. The low values for TANF > 18 bed days and readmissions are noted and warrant additional analyses to be reported at the UMC in 2020, with the appropriate interventions to improve performance as warranted.

Shared Risk - OCC	Goals	Q1	Q2	Q3
SPD				
ALOS	-	5.1	4.7	4.9
Bed Days/PTMPY	1340	1,202	1,018	1,016
Readmissions	-	20%	20%	20%
ED Visits/PTMPY	410	432	414	397
TANF>18				
ALOS	-	6.5	0.0	7.5
Bed Days/PTMPY	-	1,106	0	1,094
Readmissions	-	0%	0%	0%
ED Visits/PTMPY	-	471	537	448

NOTE: No Established Goal for OCC Shared Risk TANF > 18

OCC CCN demonstrated improvement in bed day utilization in 2019, though ED usage was higher than anticipated, especially during Q2 for the TNF > 18 population and this same population with a sharp decline in Q3. These trends warrant additional analyses to be reported at the UMC in 2020, with the appropriate interventions to improve performance as warranted.

CCN - OCC	Goals	Q1	Q2	Q3
SPD				
ALOS	-	5.6	6.5	5.3
Bed Days/PTMPY	1980	1,442	1,729	1,672
Readmissions	-	22%	33%	26%
ED Visits/PTMPY	410	627	587	635
TANF>18				
ALOS	-	5.1	4.1	1.0
Bed Days/PTMPY	-	1,197	1,668	86
Readmissions	-	0%	0%	0%
ED Visits/PTMPY	-	350	1,661	594

OC results were variable, likely related to the small population size, but did show improvement in bed day utilization for the first three quarters

OC	Goals	Q1	Q2	Q3
ALOS	-	5.1	5.2	4.0
Bed Days/PTMPY	1370	1,100	787	508
Readmissions	-	10%	19%	11%
ED Visits/PTMPY	480	509	393	431

Over and Underutilization is monitored, tracked, managed and reported by UM during 2019 and reported to UMC, QIC and the Quality Assurance Committee (QAC). The data do not reveal any significant variation in data warranting immediate intervention, however, a robust organization-wide over and underutilization monitoring process will be developed and reported to the appropriate committees during 2020.

III Operational Performance

A. Authorization for Expedited / Urgent, Standard / Routine, Retrospective Requests – Medical (This includes inpatient, outpatient and physician services).

2019 - Summary of referral volume (Quarter 1Quarter 3)

Referrals Processed		Referrals Received		Turnaround Time Compliancy (TAT)	
Routine:	**123,729**	Faxed:	**90,124**	Routine TAT:	**99.95%**
Urgent:	**15,283**	COLAS:	**100,542**	Urgent TAT:	**99.45%**
Retro:	**7,539**			Retro TAT:	**99.76%**
Total:	**146,551***	**Total:**	**190,666**		

Total volume of referrals increased from 2018 by 28,391 or 16.2%
Volume of faxed referrals increased from 2018 by 12,050 or 13.3%
Volume of portal (COLA) referrals increased from 2018 by 3,302 or 3.2%

*The difference between referrals received and processed may be attributed to duplicate submissions and/or requests that do not require authorization.

Online Referral Rate Submission
Online referral submission increased over the 3 quarters by 11% in 2019. In 2018, Q1-Q3, there were 91,334 online referrals and during the same period of 2019, there were 100,542.

Referral TAT was compliant for all referral types in the first 3 quarters of 2019.

B. Authorization for Expedited / Urgent / Routine / Retro Requests – Pharmacy

Annual summary of turnaround time compliance, through
3Q19::
OC: 100%
OCC: 99.7%
Medi-Cal: 98.8%

Pharmacy Prior Authorization TAT processing time are above the goal of 98% for all plans. Pharmacy metric targets were achieved for 2019.

C. Authorization for Expedited / Urgent / Routine / Retro Requests – LTSS (CBAS, LTC)

- LTSS consistently met required turnaround times throughout the year. LTSS metric targets were achieved for 2019 (Q1-3):
    - CBAS CEDT: 100%
    - CBAS Routine: 100%
    - CBAS Expedited: None received
        - Members participating in CBAS Q1-Q3 2019: Potentially program-eligible members

          QTR 1:
          OCC: 180/14,186 (1.27%) = Increase
          Medi-Cal: 2,457/111,227 (2.21%) = No Change

          QTR 2:
          OCC: 193/14,213 (1.36%) = Increase
          Medi-Cal: 2,500/114,939 (2.18%) = Decrease

          QTR 3:
          OCC: 205/14,171 (1.45%) = increase
          Medi-Cal: 2,568/101,012 (2.54%) = increase
        - 80% of authorized CBAS participation days will be utilized/delivered (Q1-Q3 2019).

          QTR 1:
          101,754 Days Used of 128,785 Authorized (79.01%)

          QTR 2:
          107,281 Days Used of 133,148 Authorized (80.57%)

          QTR 3:
          107,281 Days Used of 133,148 Authorized (80.57%)

        Goal Met: Continue to monitor
    - LTC Routine: 98.99%
    - LTC Urgent: None received
    - MSSP Discharges will not exceed New Admissions by more than 2 members during the quarter.

      QTR 1:
      OCC: 180/14,186 (1.27%) = Increase
      Medi-Cal: 2,457/111,227 (2.21%) = No Change

      QTR 2:
      OCC: 193/14,213 (1.36%) = Increase
      Medi-Cal: 2,500/114,939 (2.18%) = Decrease

QTR 3:
OCC: 205/14,171 (1.45%) = increase
Medi-Cal: 2,568/101,012 (2.54%) = increase

MSSP Goal met. Continue with this goal.

D. Inter-Rater Reliability (Physicians, Nurses, Pharmacy) pertains to agency quality review of UM, CBAS, MSSP, LTC by annual assessment of appropriate guideline application.

The IRR was administered in compliance with the UM Program. IRR metric targets were achieved for 2019. All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

UM Clinical Staff:
Prior Authorization: 90%
Concurrent Review: 90%
Physicians: 97%
Pharmacy: 100%
LTSS: LTC tested on Q3 for an average of 95.7%, CBAS tested in Q3 for an average of 96.6% and MSSP did not test in 2019

E. Denial (Letter) Process

Performance has continued to improve throughout 2019. A specific area of focus was the appropriate lay language, which has demonstrated significant improvement, though there remains some variability across the HNs. A workgroup begun in 2019 consisting of participants from CalOptima UM, BHI, Pharmacy, GARS and A&O that will continue to identify and share best practices to attain further improvement in this area. NCQA 2019 Survey demonstrated full compliance with the denial process across CCN and the HNs selected for review.

III. Utilization Performance / Outcomes

A. Facility Utilization – Facility Acute and Emergency Care

Analysis of inpatient and ED data in 2019 identified positive performance against goals in Bed Days/PTMPY, however, the emergency department utilization was variable, and overall, higher than established goals for this metric, as evidenced on the preceding Inpatient and Emergency Department Utilization Performance tables.

Review of 2019 ED Data will be conducted, and additional interventions may be applied as needed.

LTSS Program Members admitted to LTC NF Q1-Q3 2019: A total of 21 CBAS were admitted to an LTC for the first 3 quarters of 2019.

CBAS: Track CBAS participants who transition to LTC. Goal: To be determined after establishing baseline.

QTR 1:
Medi-Cal: 5/2,457 (0.20%)
OCC: 1/180 (0.55%)

QTR 2:
Medi-Cal: 8/2,500 (0.32%)
OCC: 0/193 (0.0%)

QTR 3:
Medi-Cal: 6/2,568 (0.23%)
OCC: 1/205 (0.49%)

LTC: Members residing in LTC:

QTR 1:
OCC: 220/14,186 (1.55%) = decrease
SPD: 5,098/111,227 (4.58%) = Increase

QTR 2:
OCC: 200/14,213 (1.41%) = decrease
SPD: 5,101/114,939 (4.44%) = Decrease

QTR 3:
OCC: 196/14,171 (1.38%) = decrease
Medi-Cal: 5,130/101,012 (5.26%) = increase

B. Pharmacy Utilization

Outpatient pharmacy utilization increases in 2019 are primarily driven by increased utilization of diabetes medications and seasonal increases in analgesics and antibiotics during the cold and flu season.

Opioid analgesic utilization (average morphine milligram equivalent) has decreased 17.6% from 3Q18 to 3Q19.

C. Member and Provider Satisfaction

Member and Provider Satisfaction with the UM Program is important to CalOptima. The following approaches are incorporated into the UM Program to promote continuous improvement in this area:

- Providing information to members and providers about the UM Program
  - Members are informed about authorization requirements through the Member Handbook and member newsletters
  - New member orientation is available for all CalOptima members to better understand their benefits
  - Access to a list of services requiring pre-authorization is also available on CalOptima's website
  - CalOptima Customer Service and clinical staff are available to assist member's in accessing services, as needed
  - Providers receive on-site visits from CalOptima's Provider Relations team, who provide tools and references for requesting authorizations for their members
  - A Provider Toolkit is available on the CalOptima website for provider reference
  - CalOptima Link provides an easily accessed electronic means of requesting authorizations for providers
- Ensuring timeliness and notification of UM decisions
  - Monitored and reported quarterly to UMC: In 2019, the percent of authorization requests completed in a timely manner overall exceeded 97.5%
- Consistent use of approved, evidence-based guidelines in clinical decision making
  - Monitored monthly by the A&O Committee
  - Variation among the delegated HNs
  - Additional training provided as needed
  - Overall improvement in audit scores for clinical decision making in 2019

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals related to the UM Program. In 2019, complaints about the UM Program demonstrated some trends in the following categories:

- Member concerns:
  - Pharmacy Home Program and quantity limits on opioid medications
  - Quality of service by pain management practitioners
  - Supplemental dental benefits
  - There was a significant decrease in the number of complaints about transportation by

OC and OCC members. This is clearly due to the new Medi-Cal non-medical transportation benefit, which became effective in July 2019

- Provider concerns:
    - Redirection from tertiary level of care for non-complex condition management
    - Level of payment disputes, especially from non-participating and/or out of area providers

While member concerns regarding the Pharmacy Home Program and quantity limits on opioid medications have risen, these controls remain as efforts to impact the strengthening opioid crisis. Provider, member and community education on the cautious and appropriate use of these medications will promote understanding of these programs. Complaints about pain management practitioners is likely a related issue. However, oversight of these providers and prompt review of any quality concerns will continue; appropriate peer review activities are performed by the Credentialing and Peer Review Committee.

CalOptima has worked closely with Liberty Dental to address complaints regarding supplemental dental benefits and recent updates to the contract should improve member experience. OCC and OC members will not have the option to select Liberty dental in 2019. The only dental benefits they have is Denti-Cal, which they will be referred to.

Provider disputes regarding redirection from tertiary level of care have begun to trend downward as CalOptima has strengthened the regular communication with UCI Medical Center through quarterly joint operations meetings. Education continues with out of area and out of network providers regarding appropriate billing practices, especially for Medi-Medi members.

IV Summary

In 2019, CalOptima made progress improving the effectiveness of the UM program and decreasing administrative barriers. We also brought on a pool of expertise to enhance our programs, including a pediatric physician with CCS expertise to assist with WCM. Major initiatives included improvements to CalOptima's medical management system and network data interfaces as well as continued focus on Compliance, maintenance of current policies and procedures, report development, preparation for the Whole-Child Model transition leveraging existing processes and model(s) of care.

The UMC and the UM Medical Director continue to guide and support CalOptima UM programs, as well as the Deputy CMO position which was resurrected and filled during 2019. New management staff were brought on during Q3 of 2019, which includes a UM Director and PA Manager. Our overall referral volume increased during 2019, however, compliance with regulatory standards remained strong for CCN/COD. Deficiencies in HN performance as noted in the preceding "UM Delegated Provider Oversight" section were identified by the Audit and Oversight team and CAPs were issued.

20~~19~~20 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

202019 UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

~~Francesco Federico~~Himmet Dajee, M.D. **Date**
Utilization Management Medical Director

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Paul Yost, M.D. **Date**

Board of Directors Chair:

_____ _____

Paul Yost, M.D. **Date**

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members is in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well- coordinated system of care to ensure optimal health outcomes for all members.

Our Values — CalOptima CARES

Collaboration: We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability: We were created by the community, for the community, and are accountable to the community. Meetings open to the public are: ~~Our~~ Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, ~~Quality Assurance Committee and Finance and Audit Committee meetings are open to the public~~and Whole-Child Model Family Advisory Committee.

Respect: We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.
-

Excellence: We base our decisions and actions on evidence, data analysis and industry- recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship: We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

We are "Be-tte-r. Togeth-er."
We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan
CalOptima's 2017–19 Strategic Plan honors our long-standing mission focused on members while recognizing that the future holds some unknowns given possible changes for Medicaid plans serving low-income people through the Affordable Care Act. Still, any future environment will demand attention to the priorities of more innovation and increased value, as well as enhanced partnerships and engagement. Additionally, CalOptima must focus on workforce performance and financial strength as building blocks so we can achieve our strategic goals. Below are the key elements in our Strategic Plan framework.

Strategic Priorities:

- **Innovation:** Pursue innovative programs and services to optimize member access to care.
- **Value:** Maximize the value of care for members by ensuring quality in a cost-effective way.
- **Partnerships and Engagement:** Engage providers and community partners in improving the health status and experience of members.

Building Blocks:

- **Workforce Performance:** Attract and retain an accountable and high-performing workforce capable of strengthening systems and processes.
- **Financial Strength:** Provide effective financial management and planning to ensure long- term financial strength.

In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is unusual in that ~~IT IS~~ it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimo~~n~~al health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures**,** including providing opportunities for stakeholder input.
- Be accountable for the decisions we make

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. ~~For more than 20 years, CalOptima has been serving~~ Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population~~. Due to the implementation of the Affordable Care Act — as more low-income children and adults qualified for Medi-Cal — membership in CalOptima grew by an unprecedented 49% between 2014 and 2016!~~

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, ACA expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima~~,~~ but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.
- Dental services are provided through California's Denti-Cal program.

Members with Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including Orange County Health Care Agency (OC HCA) and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, the Department of Health Care Services (DHCS) integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members into the scope of benefits provided by CalOptima. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. –

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)

- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare ~~(HMO SNP)~~

Our OneCare (HMO SNP) ~~(OC)~~ members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OneCare (OC) to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for ~~the~~ dual eligible members~~,~~ enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County, and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services
In addition to the comprehensive scope of acute~~, and~~ preventive care and behavioral health services covered under Medi--Cal and Medic ~~C~~are benefits, CalOptima OC members are eligible for enhanced services such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal.

These members ~~often~~ frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and an out of the country urgent/emergency care benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in~~s~~ a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi- Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services
OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute~~, and~~ preventive care and behavioral health services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits such as vision care, ~~and~~ gym benefits, over-the-counter medication benefits and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community- based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitcians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participantstes. PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

PROGRAM INITIATIVESPROGRAM INITIATIVES

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by Department of Health Care Services (DHCS) as part of California's Medi-Cal 2020 2017–2019 sStrategic pPlan.:. IiIn Orange County, the pilot is being the pilot is being led by the OC HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. Thein 2019, the WPC Connect information sharing platform was launched in November 2018. For 20192020, the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. Currently, CCS services are carved out (separated) from most Medi-Cal managed care plans, including CalOptima. In Orange County, OC HCA manages the local CCS program. OC HCA provides case management, eligibility determination, service authorization and direct therapy under the Medical Therapy Program.

As of July 1, 2019, tThrough SB 586, the Sstate has required CCS services to become a CalOptima Medi-Cal managed care plan benefit in select counties. The goal of this transition wasis to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. This approach is known as Tthe Whole-Child Model (WCM)

successfully transitions to CalOptima in 2019**.** ~~-~~Under this ~~model,~~program in Orange County, medical eligibility determination processes~~, and~~ the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with OC HCA.

~~, while other CCS program components are transferred to CalOptima. CalOptima had~~

~~originally expected to launch WCM effective January 1, 2019, but recently DHCS delayed the WCM implementation in Orange County, and the new implementation date is now no sooner than July 1, 2019.~~

Health Homes Program ~~(HHP)~~

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima planned~~s~~ to implement HHP in the following two phases: ~~July~~ January 1, 2020~~,19~~ for members with chronic physical conditions or substance use disorders (SUD), and ~~January~~ July 1, 2020~~,~~ for members with serious mental illness or Serious Emotional Disturbance (SMI).

~~DHCS~~ CalOptima's goal is to target~~ing~~ the highest-risk 3–5 percent~~%~~ of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. ~~DHCS sends~~will send a targeted engagement list of members to CalOptima for review and outreach, as appropriate. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions~~;~~ and
2. Meet specified acuity/complexity criteria~~.~~

Members eligible for HHP must consent to participate and receive HHP services. CalOptima ~~will be the Lead Administrative Entity and~~ is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary ~~health home~~HHP providers. In addition to CalOptima's Community Network, ~~some~~ all health networks (HN)~~s~~ will ~~may~~ serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing related and accompaniment services to further support HHP members. Following implementation, CalOptima will consider opportunities for other entities to participate.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. To address this problem, Orange County has focused on creating a system of care that uses a

multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health; health care; housing support services; community co~~rrections~~nnections; and public social services. The county's WPC program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care — As part of the Whole Person Care program, services provide post-acute care for up to 90-days for homeless CalOptima members.
- Medical Respite Care — As an extension to the recuperative care program, CalOptima provides additional respite care beyond the 90 days of recuperative care under the Whole Person Care program.
- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), Orange County Health Care Agency's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members.
- Homeless Clinical 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 preventive care services at Orange County homeless shelters.

Hospital Discharge Process for Members Experiencing Homelessness — Support is provided to assist hospitals with the increased cost associated with discharge planning under new state requirements.

Population Health Management (PHM)

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping Members Healthy
2. Managing Members with Emerging Risks
3. Patient Safety or Outcomes Across Settings
4. Managing Multiple Chronic Conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima has developed a comprehensive PHM Strategy, which ~~for 2019. The 2019 PHM Strategy~~ includes ~~a plan of~~ actions ~~f~~to~~or~~ address~~ing~~ the needs of our culturally diverse members ~~needs~~ across the continuum of care based on the National Quality Assurance Committee (NCQA) Population Health Management standards. ~~released in July 2018~~. CalOptima's PHM Strategy aims to ensure that ~~the~~ care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

CalOptima's ~~The 2019~~ PHM Strategy is based on numerous efforts to assess the health and well-being of our~~CalOptima~~ members, such as the Member Health Needs Assessment ~~that was completed in March 2018~~. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101.

The PHM strategy ~~plan of action~~ addresses the unique needs and challenges of specific ethnic

communities including economic, social, spiritual, and environmental stressors, to improve health outcomes.

~~In the first year, the PHM Strategy will be focused on expanding the Model of Care while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus with an integrated model. CalOptima added the PHM Value Based Payment Arrangement as the foundation to align the future Pay for Value program methodology.~~

WITH WHOM WE WORK ~~CALOPTIMA'S PROVIDER NETWORKS:~~

Contracted Health Networks/Contracted Network Providers
Providers have several options for participating in CalOptima's programs ~~to~~ providinge health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct-Administration and/or CalOptima Community Network (CCN) and/or contract with a CalOptima health network (HN).~~, and/or participate through CalOptima Direct, and/or the CalOptima Community Network.~~ CalOptima members can choose CCN or one of 134 ~~-~~ HNs, representing more than 8,500 practitioners.

~~**Health Networks (HN)**~~
~~CalOptima contracts with a variety of HN models to provide care to members. Since 2008, CalOptima's HNs consist of:~~

- ~~Health Maintenance Organizations (HMOs)~~
- ~~Physician/Hospital Consortia (PHCs)~~
- ~~Shared Risk Medical Groups (SRGs)~~

~~Through these HNs, CalOptima members have access to more than 1,600 Primary Care Providers (PCPs), more than 6,700 specialists, 23 hospitals, 23 clinics and 100 long-term care facilities.~~

CalOptima Direct (COD)
CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)
CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including dual-eligible ~~s~~ (those with both Medicare and Medi-Cal who elect not to participate in ~~CalOptima's OneCare~~CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. Members enrolled in CalOptima Direct-Administrative are not HN eligible.

CalOptima Community Network (CCN)
The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN ~~N~~

is administered internally by CalOptima and available for members to select, supplementing the ~~existing~~ HN delivery model and creating additional capacity for growth.

~~**The following are CalOptima's contracted health networks:**~~

CalOptima Contracted Health Networks

CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

Health Network/Delegate	Medi Cal	One Car	OneCa re
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC	SRG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	HMO	SRG	HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Medical Group	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management (UM)
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities

~~MEMBERSHIP DEMOGRAPHICS~~MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2020

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

Membership Data as of November 30, 2019

Total CalOptima Membership
755,539

Program	Members
Medi-Cal*	739,601
OneCare Connect	14,065
OneCare (HMO SNP)	1,498
Program of All-Inclusive Care for the Elderly (PACE)	375

Note: The Fiscal Year 2019-20 Membership Data began on July 1, 2019.
*Includes prior year adjustment

Member Age (All Programs)

11%	0 to 5
29%	6 to 18
29%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
27%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

CalOptima
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Fast Facts: December 2019

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

Membership Data as of October 31, 2019

Total CalOptima Membership
743,465

Program	Members
Medi-Cal*	727,437
OneCare Connect	14,093
OneCare (HMO SNP)	1,567
Program of All-Inclusive Care for the Elderly (PACE)	368

Note: The Fiscal Year 2019-20 Membership Data began on July 1, 2019.
*Includes prior year adjustment

Member Age (All Programs)

11%	0 to 5
29%	6 to 18
29%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
27%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

~~UTILIZATION~~ UTILIZATION MANAGEMENT ~~MANAGEMENT~~ PROGRAM ~~PROGRAM~~

UM Purpose

The purpose of the Utilization Management (UM) Program Description is to define CalOptima's structure and processes for ~~to~~ review of health care services, treatment and supplies, including assignment of responsibility to appropriate individuals, to deliver quality, coordinated health care services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, cost effective and timely manner by delegated and non-delegated providers.

UM Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive, emergency, primary, specialty, behavioral health, home and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima members.

- Assist in the coordination of medically necessary medical and behavioral health care services in accordance with state and federal laws, regulations, contract requirements, NCQA Standards and evidence-based clinical criteria.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address concerns about access, availability, and timeliness of care.
- Clearly define staff responsibility for activities regarding decisions based on medical necessity.
- Establish and maintain processes used to review medical and behavioral health care service requests, including timely notification to members and/or providers of appeal rights when an adverse ~~benefit~~ determination is made based on Medical Necessity and/or ~~covered~~benefit coverages ~~availability~~.
- Identify and refer high-risk members to Case Management Programs, including Complex Case Management, ~~Long-Term Services and Supports (~~LTSS~~)~~, Behavioral Health and/or Population Health Management services, as appropriate.
- Promote a high level of member, practitioner and stakeholder satisfaction.
- Protect the confidentiality of member protected health information and other personal information.
- Identify potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- Identify issues that contribute to over or underutilization or the inefficient or inappropriate use of health care services.
- Promote improved member health and well-being by coordinating services with appropriate

county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health ~~and CCS~~.

- Educate practitioners and other providers, including delegated HNs, on CalOptima's UM Program, policies and procedures.

- Monitor utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.

UM Program Structure

The UM Program is designed to work collaboratively with delegated entities, including, but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community in an effort to assure that the member receives appropriate, cost efficient, quality- based health care.

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA) and NCQA at least annually. The UM Program is revised and improved, as appropriate. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network.

Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization.

The organization chart and the UM Program's committees reporting structure reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

The UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer; Deputy Chief Medical Officer; Medical Director(s) of UM; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima delegates UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM Program Description and CalOptima policies and procedures. Delegation is dependent upon the following factors:

- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards as documented in the UM policies and procedures, including timeframes outlined in CalOptima's policies and procedures. ~~(GG.1508: Authorization and Processing of Referrals; Attachment A, Timeliness of UM Decisions and Notifications.)~~

CalOptima retains accountability for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:

- Frequent reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight department, Utilization Management Committee (UMC) and/or Quality Improvement Committee (QIC).
- Regular audits of delegated HNs ~~utilization management~~UM activities by the Audit and Oversight

department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA and CalOptima standards and program requirements.

- Annual approval of the delegate's UM program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.

In the event the delegated provider does not adequately perform contractually specified delegated duties, CalOptima takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation adjustments, or de-delegation.

Long-Term Services and Supports ~~(LTSS)~~

CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima is responsible for clinical review and medical necessity determination for the following levels of care:
  - Nursing Facility Level B (NF-B)
  - Nursing Facility Level A (NF-A)
  - Subacute Adult and Pediatric
  - ~~o~~

- ~~Intermediate Care Facility/Developmentally Disabled, (ICF/DD)~~
- ~~Intermediate Care Facility/Developmentally Disabled-Habilitative, (ICF/DD-H)~~
- ~~Intermediate Care Facility/Developmentally Disabled-Nursing, (ICF/DD-N)~~

- Medical necessity for LTC is evaluated based upon the DHCS Medi-Cal Criteria Chapter, Criteria for Long-Term Care Services, and Title 22, CCR, Sections 51118, 51120, 51121, 51124, 51212, 51215, 51334, 51335, 51343, 51343.1 and 51343.2.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization. CalOptima evaluates medical necessity for services using the CBAS Eligibility Determination Tool (CEDT).
- MSSP: Home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for long-term nursing facility care. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization. The CalOptima MSSP site adheres to the California Department of Aging contract and eligibility determination criteria.

Behavioral Health Services

Medi-Cal

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. ~~Mental~~ Behavioral ~~h~~Health (BH) services include but are not limited to: individual and group psychotherapy, psychology, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger that meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific timeframe. CalOptima provides direct oversight, review, and authorization of BHT services.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) (formerly Screening, Brief Intervention, and Referral to Treatment [SBIRT]) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at **855-877-3885**. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

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CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits including ~~utilization management~~UM, claims, credentialing the provider network, member services~~,~~ and ~~quality improvement~~QI.

OC and OCC

CalOptima ~~has~~ previously contracted with Magellan Health Inc., to directly manage the ~~mental health~~BH benefits for OC and OCC members. Effective 1/1/2020, OC~~/~~ and OCC covered ~~behavioral health~~ BH services ~~will be~~were full~~ing~~y integrated within CalOptima internal operations. ~~Functions delegated to Magellan include provider network, UM, credentialing, and customer service.~~ OC and OCC members can access ~~mental health~~BH services by calling the CalOptima Behavioral Health Line. Members will be connected to CalOptima representative for ~~behavioral health~~BH assistance.

~~CalOptima OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. By selecting the OC or OC C option, the member will be transferred to a Magellan representative for a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within Magellan Health Inc. provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.~~

CalOptima offers ~~Alcohol Misuse Screening and Counseling (~~AMS~~A~~C~~)~~ services in the PCP setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

Linkages with Community Resources

In addition, CalOptima provides linkages with community programs to members with special health care needs, or high risk or complex medical and developmental conditions. These linkages are established through special programs, such as the CalOptima Community Liaisons, PCCs, ~~Behavioral Health~~BH Integration (BHI), ~~Long-Term Services and Supports (~~LTSS~~)~~ and specific program contracts and MOUs with other community agencies and programs, such as the OC HCA's CCS, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate state agencies and specialist care when the benefit coverage of the member dictates. The UM department coordinates activities with the Case Management department to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

AUTHORITY, BOARDS OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors
The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and service provided to CalOptima members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) — which oversees the functions of the QI Committee described in CalOptima's State and Federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as discussed below.

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. ~~CalOptima~~ The Board promotes ~~promotes~~ the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to ~~the Chief Medical Officer (~~CMO~~)~~. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIC and the QAC on an annual basis.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the QAC to review and make recommendations to the Board regarding accepting the overall QI Program and annual evaluation, and routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and improvements achieved. The QAC also makes recommendations for annual modifications of the QI Program and actions to achieve the Institute for Healthcare Improvement's Quadruple Aim ~~moving upstream~~ expanding on ~~from~~ the CMS' Triple Aim:

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee
The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventative services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children

- Consumers
- Family support
- Foster children
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons
- OC HCA
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by OC HCA and OC SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - OC SSA
    - OC Community Resources Agency, Office on Aging
    - OC HCA, Behavioral Health
    - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent a broad provider community that serves CalOptima members. The PAC is comprised of 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of OC HCA, which maintains a standing seat. PAC meets at least quarterly and are open to the public. The 15 seats include:

- HN
- Hospitals
- Physicians (3 seats)
- Nurse
- Allied health services
- Community health centers
- OC HCA (1 standing seat)
- LTSS (LTC facilities and CBAS) (2 seats)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

In 2018, CalOptima's Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC), as required by the state as part of California Children's Services (CCS) becoming a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning WCM, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima WCM. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: 7–9 seats
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
    - CalOptima members age 18–21 who are a current recipient of CCS services; or
    - Current CalOptima members over the age of 21 who transitioned from CCS services
- Interests of children representatives: 2 to 4 seats

- Community-based organizations; or
- Consumer advocates

Members of the Committee shall serve staggered two-year terms. Of the above seats, five members serve an initial one-year term (after which representatives for those seats will be appointed to a full two-year term), and six will serve an initial two-year term. WCM FAC meets at least quarterly and meetings are open to the public.

Role of CalOptima Officers for ~~Quality Improvement~~UM Program

CalOptima's CMO, Chairperson of the UMC, Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the State and Federal Contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO), along with the Deputy Chief Medical Officer (DCMO) oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members.
~~The CMO, along with the Deputy Chief Medical Officer (DCMO) or physician designee oversees CalOptima's UM Program, including the strategies, programs, policies and procedures related to CalOptima's medical care delivery system.~~ At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO),
~~The Deputy Chief Medical Officer~~ along with the ~~Chief Medical Office (~~CMO~~)~~ oversees the strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Services and Supports (LTSS) and Enterprise Analytics (EA).

Executive Director, Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Case Coordination, Complex Case Management, and Managed ~~Long- Term Services and Support~~LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO, DCMO and the ~~Executive Director~~ED, ~~Quality & Analytics (ED of Q&A~~ of Quality and Population Health Management (Q&PHM~~)~~, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational

efficiencies consistent with CalOptima's strategic plan, goals and objectives. The ED of C-O is expected to anticipate, continuously improve, communicate and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources.

Medical Director, Utilization Management~~,~~ is appointed by the CMO and/or DCMO, and is responsible for the direction of the UM Program objectives, as well as evaluation of the UM Program ~~to drive the organization's mission, strategic goals and processes to provide high quality care to CalOptima members in a compassionate and cost-effective manner~~. The ~~M~~medical

~~D~~ddirector ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. The ~~M~~mmedical ~~D~~ddirector ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and utilizes evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the ~~Medical~~ medical ~~Director~~ director ~~of UM~~ also provides supervisory oversight and administration of the UM Program ~~. In this role, the Medical Director~~and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. ~~Medical Director of UM p~~Provides clinical education and in-service~~s~~ training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The ~~M~~mmedical ~~D~~ddirector of UM ensures physician availability to staff during normal business hours and on-call after hours. ~~He or she~~Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the bi-weekly UM Workgroup meetings and participates in the CalOptima Medical Directors Forum and QIC.

Medical Director, Behavioral Health is the designated behavioral healthcare practitioner in the QI and UM programs, and serves as a participating member of the UMC, QIC and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and ~~behavioral health~~BH care services for CalOptima members. ~~The Medical Director provides c~~Clinical oversight is also provided for ~~behavioral health~~BH benefits and services provided to members. The ~~M~~mmedical ~~D~~ddirector works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality ~~behavioral health~~BH outcomes. ~~The Behavioral Health~~Additionally, the ~~M~~mmedical ~~D~~ddirector is involved in the implementation, monitoring, evaluating and directing of the behavioral health aspects of the UM Program.

Medical Director, Senior Programs is a key member of the medical management team and is responsible for the Medi-Medi programs (~~OneCare~~ OC and ~~OneCare Connect~~OCC), ~~Managed LTSS (~~MLTSS~~)~~ programs, Case Management and Transitions of Care programs. The ~~M~~mmedical ~~D~~ddirector provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The ~~M~~mmedical ~~D~~ddirector works in collaboration with the other ~~M~~mmedical ~~D~~ddirectors and the clinical staff within ~~Population Health Management~~PHM, ~~Grievance and Appeals~~GARS, and Provider Relations. The ~~M~~mmedical ~~D~~ddirector works closely with the nursing and non-clinical leadership of these departments.

Medical Director, Population Health Management~~/~~, Health Education~~/~~, Program for All Inclusive Care for the Elderly (PACE) ~~Programs~~ is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of PHM, disease management and health education programs, while also providing clinical quality oversight of the PACE- Center~~Program~~.

Director, Utilization Management

Director is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in Utilization Management (UM) departmental operations. This position will provide leadership and direction to the Utilization Management department to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. The incumbent will have oversight of CalOptima's Utilization Management program for CalOptima Community

Network, CalOptima Direct and the delegated health networks. The Director is expected to serve as a liaison for various internal and external committees, workgroups, and operational meetings.
~~is responsible for directing and coordinating the planning, organization, implementation and evaluation of all activities and personnel engaged in UM departmental activities. The director develops and implements the UM Program, and UM Work Plan, maintains and updates policies, procedures and work flowsworkflows to meet regulatory, contractual and accreditation standards.~~

Director, Behavioral Health Services provides operational oversight for ~~behavioral health~~BH benefits and services provided to members. The director is responsible for monitoring, analyzing, and reporting to senior staff on changes in the health care delivery environment and program

opportunities affecting or available to assist CalOptima in integrating physical and ~~behavioral health~~BH care services. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, ~~and~~ executive staff, members, providers, HN management, legal counsel, state and federal officials, and representatives of other agencies.

Director, Quality Improvement is responsible for assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED of ~~Quality~~ Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

Director, Quality Analytics provides data analytical direction to support quality measurement activities for the agency-wide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory, and accreditation agencies.

Director, Population Health Management provides direction for program development and implementation for agency-wide population health initiatives. Ensures linkages supporting a whole-person perspective to health and health care with Case Management, UMC, Pharmacy, and ~~Behavioral Health Integration~~BHI. Provides direct care coordination and health education for members participating in non-delegated health programs such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

Director(s), Audit and Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima policies, and industry best practices. The directors ensure~~s~~ that CalOptima and its subcontracted ~~health network~~HNs perform consistently with both CMS and state requirements for all programs. Specifically, the directors lead~~s~~ the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the directors are responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. These positions interact with the Board of Directors, CalOptima executives, departmental management, HN management and Legal Counsel.

~~UM~~ RESOURCES

UM Resources

The following staff positions provide support for the UM department's organizational/operational functions and activities:

Manager, Utilization Management~~r~~ **(Concurrent Review ~~Manager~~ [CCR])** manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The manager develops,

implements, and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in UM activities.

Supervisor, Utilization Management (CConcurrent Review) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The supervisor is a resource to the CCR staff regarding CalOptima policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training and in-servicing activities. The supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years of managed care experience preferred
- Supervisor experience in Managed Care/UM preferred.

Manager, Utilization Management (Prior Authorization [PA]), manages the day-to-day operational activities of the department to ensure staff compliance with company CalOptima policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in Utilization Management activities.

Supervisor, Utilization Management (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff — regarding CalOptima policies and procedures as well as

regulatory requirements governing prior and retrospective authorization processing — while providing ongoing monitoring and development of staff through training ~~and in-servicing~~ activities. The supervisor also monitors for documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted RN license or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years of managed care experience.
- Supervisor and/or Lead experience in Managed Care/UM preferred.

Notice of Action Medical Case Managers (RN/LVN)~~RNs~~ draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria. These positions audit clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, ensures denial reason is written in plain language that a lay person understands,- is specific to the clinical information presented and criteria referenced and is prepared using the appropriate threshold language template. They work with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

Experience & Education

- Current and unrestricted California Board LVN or CA RN license.~~RN in the State of California~~
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years managed care experience
- Excellent analytical and communication skills required

Medical Case Managers (RN/LVN) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality, and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria. This activity is conducted prospectively, concurrently, or retrospectively. They also provide concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs, PHCs, and SRGs; and act as liaisons to Orange County based community agencies in the delivery of health care services. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- Current and unrestricted California Board LVN or RN license.
- Minimum of 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Medical Authorization Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case

Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They also authorize requested services according to departmental guidelines. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- High school graduate or equivalent; a minimum of 2 years of college preferred.
- 2 years of related experience that would provide the knowledge and abilities listed.

Program Specialist provides high-level administrative support to the Director, UM, the UM Managers, Supervisors and the UM Medical Directors.

Experience & Education

- High school diploma or equivalent; a minimum of 2 years of college preferred.
- 2–3 years previous administrative experience preferred. Courses in basic administrative education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.
-

Pharmacy Department Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements, and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery, including, but not limited to, the contract with the third-party auditor, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies, and pharmacy organizations.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Doctor of Pharmacy (Pharm.D) required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have developed the knowledge and abilities listed.

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima Delegated Health Plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, researches, develops, and updates drug UM strategies and intervention techniques. The

Pharmacy manager develops and implements methods to measure the results of these programs, assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T), Committee ~~(P&T)~~, interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- At least 3 ~~years' experience~~years' experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Clinical Pharmacists assist the Pharmacy ~~D~~director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima H~~ealth~~ N~~etwork~~s and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs. They assist the Pharmacy director in preparing drug monographs and reports for the P&T, interact frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- 3 years of~~'~~ experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

Experience & Education

- Pharm.D degree from an accredited college of pharmacy.
-

- Eligibility for licensure in California.

~~PBM (~~Pharmacy Benefits Manager~~)~~ (PBM)** staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's P&T. CalOptima pharmacists with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria, ~~. CalOptima pharmacists with a current license to practice without restriction~~ and perform all denials.

LTSS Resources

The following staff positions provide support for LTSS operations:

Director, Long-Term Support Services develops, manages and implements LTSS, including Long-Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs. The director is responsible for ensuring high quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. The director also develops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF~~/ICF-DD/N/H~~) and other LTSS services.

Experience & Education

- Bachelor's degree in Nursing or in a related field required.
- Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable.
- 5–7 years varied related experience, including ~~five~~ 5 years of supervisory experience with experience in supervising groups of staff in a similar environment.
- Some experience in government or public environment preferred.
- Experience in the development and implementation of new programs.

Manager, Long-Term Support Services (CBAS/LTC) is expected to develop and manage the LTSS department's work activities and personnel. The manager ensures that service~~s~~ standards are met, and operations are consistent with CalOptima's policies and regulatory and accrediting agency requirements to ensure high quality and responsive service~~s~~ for CalOptima's members who are eligible for and/or receiving LTSS. This position must have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, ~~health network~~HNs, and other internal and external customers in a professional and competent ~~manager~~manner. The manager works in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving ~~LTC~~ LTSS services.

Experience ~~&and~~ Education

- A current and unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5–7 years varied clinical experience required.
- 3–5 years supervisory/management experience in a managed care setting and/or nursing facility.
- Experience in government or public environment preferred.
- Experience in health with geriatrics and persons with disabilities.

Supervisor, Long-Term Support Services (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting. This position is responsible for the management of the day-to-day operational activities for LTSS programs: LTC, CBAS, and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor resolves member and provider issues and barriers, ensuring excellent customer service. Additional responsibilities ~~include:~~include managing staff coverage in all areas of LTSS to complete assignments, and orientation and training of new employees to ensure contractual and regulatory requirements are met.

Experience &~~and~~ Education

- A current unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years varied experience at a health plan, medical group, or skilled nursing facilities required.
- Experience in interacting/managing with geriatrics and persons with disabilities.
- Supervisory/management experience in UM activities.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.

Medical Case Managers, Long-Term Support Services (MCM LTSS), are part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for CalOptima members in LTC facilities and members receiving CBAS. They review and determine medical eligibility based on approved criteria/guidelines, NCQA standards, and Medicare and Medi-Cal guidelines, and facilitate communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality and cost-effective outcomes. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. These positions are the subject matter experts and acts as liaisons to Orange County based community agencies, CBAS centers, skilled nursing facilities, members and providers.

Experience &~~and~~ Education

- A current and unrestricted RN license or LVN license in the State of California~~ or a current unrestricted LVN license in the State of California~~.
- Minimum of 3 years managed care or nursing facility experience.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time.
-

Program Manager, ~~CBAS~~ LTSS is responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. This position is responsible for the annual CBAS Provider Workshop, CBAS process improvement, reporting requirements, reviewing the monthly files audit, developing inter-rater reliability questions, performing psychosocial and functional assessments, and serving as a liaison and key contact person for DHCS, California Department Office of Aging (CDA), CBAS Coalition and CBAS centers. The manager is responsible for developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.

Experience & Education

- ~~—~~Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required.
- Masters preferred.
- Minimum of 3 years CBAS and program development experience.
- Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.
- Previous work experience in managing programs and building relationships with community partners is preferred.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office (approximately 5% of the time or more will involve traveling to CBAS centers and community events).

Behavioral Health Integration ~~(BHI)~~ Resources

The following staff positions provide ~~utilization management~~UM support for Behavioral Health Integration (BHI) operations:

Manager, Behavioral Health (Care Management) is responsible for ~~managing behavioral health treatment (BHT) services, including applied behavior analysis (ABA), for members that meet medical necessity criteria. The manager oversees care managers who review assessments and treatment plans submitted by providers for adherence to BHT "best practice" guidelines. The manager designs and implements processes to ensure effective delivery of BHT services.~~ overseeing the development, implementation, and daily operations of the Care Management teams including Transitional Care Management and ~~Behavioral Health Treatment (~~BHT~~)~~ services. ~~The~~ The position ensures the delivery of quality and consistent concurrent review, recommendations, and referrals in accordance with CalOptima policies and procedures as well as ~~This position~~ collaborates with other internal CalOptima departments to ensure all regulatory requirements are met.

Experience & Education

- Master's degree in Behavioral Health or other related degree is required.
- ~~—~~A current and unrestricted ~~Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.~~
- Licensed Clinical Social Worker (~~(~~LCSW)~~,~~ or Licensed Marriage and Family Therapist (~~-~~LMFT) license in the State of California required, Licensed Psychologist~~)~~ is preferred.
- 4~~+~~ years of supervisor or manager level experience ~~in clinical management of ABA services is~~

required.

- 1 year ~~3+ years of experience providing ABA therapy to children diagnosed with ASD is required.~~
- ~~E~~experience in behavioral health audits (including CMS, DHCS, DMHC~~,~~ and NCQA).
- 1-year e~~E~~xperience in developing policies and procedures to meet federal and state regulatory requirements.
- 1-year experience in developing sound and responsible business plans and financial models preferred.

Program Manager, Sr. (B~~ehavioral H~~ealth~~)~~ is responsible for regulatory requirements governing authorization processing, monitoring utilization patterns, and developing ~~behavioral health~~BH ~~utilization management~~UM goals and activities. ~~-~~The position works under the direction of the Director~~, of~~ Behavioral Health Services (Integration), Medical Director of Behavioral Health and/or other department leadership to support the department's UM activities.

Experience & Education

- Bachelor's degree in a behavioral health related field required; Master's degree in Health Administration, Social Work, Marriage and Family Therapy, Public Health, or other related degree preferred.
- 4 years~~'~~ of experience working in a managed care environment, with specific experience in ~~behavioral health utilization management~~BH UM.
- 4 years of supervisor or manager level experience required.
- Experience in a government or public environment strongly preferred.
- 2 years of~~'~~ experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program required.
- 2 years~~'~~ of experience and aptitude for working in a highly matrixed, mission-driven organization required.

Supervisor, Behavioral Health, (BHT) is responsible for the daily operation of the BHT services program. The position oversees Applied Behavior Analysis (ABA) Member Liaison Specialists ensuring members receive appropriate provider linkage. The Supervisor will also oversee and assist Care Managers with reviewing assessments and treatment plans submitted by providers for adherence to BHT "best practice" guidelines. The Supervisor is accountable for establishing and achieving quality and productivity standards for the teams and for ensuring compliance with department policies and procedures. ~~**UM** is responsible for the UM functions within the BHI department. The supervisor monitors and oversees the department's UM work activities to ensure that member's behavioral health service needs are coordinated with medical service requests, and service standards are met. The supervisor serves as a resource to staff regarding CalOptima policies and procedures and is responsible for regulatory requirements governing authorization processing and monitoring utilization patterns. The position directly supervises the medical case managers.~~

Experience & Education

- Master's degree in Behavioral Health or other related degree is required.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- 3~~+~~ or more years of supervisor level experience in clinical management of ABA services is required.
- 3~~+~~ or more years of experience providing ABA therapy to children diagnosed with autism spectrum disorder (ASD) is required.

~~Experience & Education~~

- ~~Graduate of an accredited School of Nursing or bachelor's degree in behavioral health related area required.~~
- ~~Current and unrestricted California Board Licensed RN or LCSW required.~~
- ~~Minimum of 3 years of behavioral health experience.~~
- ~~Minimum of 3 years of supervisory experience, preferably in a managed care setting.~~
- ~~Strong written and analytical skills required.~~
- ~~Experience with ABA preferred~~

Medical Case Managers (~~RN~~ ~~Behavioral Health~~) are responsible for clinical review and recommendations related to Interdisciplinary Care Team (ICT) meetings, inpatient and outpatient psychiatric authorization requests from ~~Behavioral Health~~BH providers and completing inpatient ~~Concurrent Review (~~CCR~~)~~ and transitional care for ~~OneCare/OneCare Connect~~OC and OCC members. ~~-~~ They are responsible for adhering to CalOptima's prior authorization approval process which includes reviewing authorization requests for medical necessity, consulting with the ~~M~~manager~~,~~ and ~~CalOptima~~ Medical Director as needed. ~~-~~They also review prior authorization requests for outpatient mental health services.

~~are responsible for the oversight and review of ABA services offered to members that meet the medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from behavioral health providers. This position is also responsible for utilization management and monitoring activities of autism services provided in community-based setting. The manager directly interacts with provider callers, acting as a resource for their needs. The position is also responsible for reviewing and processing authorizations for psychological testing.~~

Experience & Education

- Current and unrestricted RN license to practice in the State of California ~~and a~~
- ~~m~~Minimum of ~~three (~~3~~)~~ years current ~~behavioral health~~BH clinical experience or an equivalent combination of education and experience required.

- Active Certified Case Manager (CCM) certification preferred.
- Experience in a prior authorization and/or managed care environment preferred.
- Experience with inpatient concurrent review strongly preferred.

~~Current LVN/RN license to practice in the State of California and a minimum of three (3) years current clinical experience or an equivalent combination of education and experience required.~~

Medical Case Manager (~~LVN – Behavioral Health~~) is responsible for reviewing and processing requests for authorization and notification of psychological testing and psychiatric inpatient services from health professionals, clinical facilities and ancillary providers. The position is responsible for prior authorization and referral related processes related to transitional care. Utilizes ~~CalOptima's~~ medical criteria, policies, and procedures to authorize referral requests from ~~behavioral health~~BH professionals, clinical facilities and ancillary providers

Experience & Education

- High school diploma required, Associates or ~~b~~Bachelor's degree in related field preferred
- Current and unrestricted LVN license to practice in the State of California required
- 3 years of clinical experience required
- Inpatient behavioral health experience preferred
- Active CCM certification preferred

Care Manager is responsible for the oversight and review of BHT services offered to members that meet medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from ~~behavioral health~~BH providers. This position is also responsible for ~~utilization management~~UM and monitoring activities of autism services provided in community-based setting. The manager directly interacts with provider callers, acting as a resource for their needs.

Experience & Education

- Master's degree in Behavioral Health or another related field is required.
- Board Certified Behavioral Analyst (BCBA) or ~~Board Certified~~Board-Certified Behavioral Analyst-Doctoral (BCBA-D) is required.
- 4~~+~~ or more years providing ABA therapy to children diagnosed with ASD is required.
- ~~Possess~~ Experience ~~clinical~~in clinical, medical utilization review, and/or quality assurance ~~experience~~ is preferred.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Member Liaison Specialist (Autism) is responsible for providing care management support to members that meet medical necessity criteria seeking BHT services, including ABA. This position assists members in linking BHT services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the ~~behavioral health~~BH system of care. This position will act as a consultative liaison to assist members, ~~health network~~HNs and community agencies to coordinate BHT services.

Experience & Education

- High school diploma or equivalent is required.
- Bachelor's degree in behavioral health or related field is preferred.
- 2 years of experience in behavioral health, community services, or other social services setting required.
- Experience in working with children diagnosed with ASD.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.
- Driver's ~~L~~license and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Qualifications and Training

CalOptima seeks to recruit ~~highly qualified~~highly qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

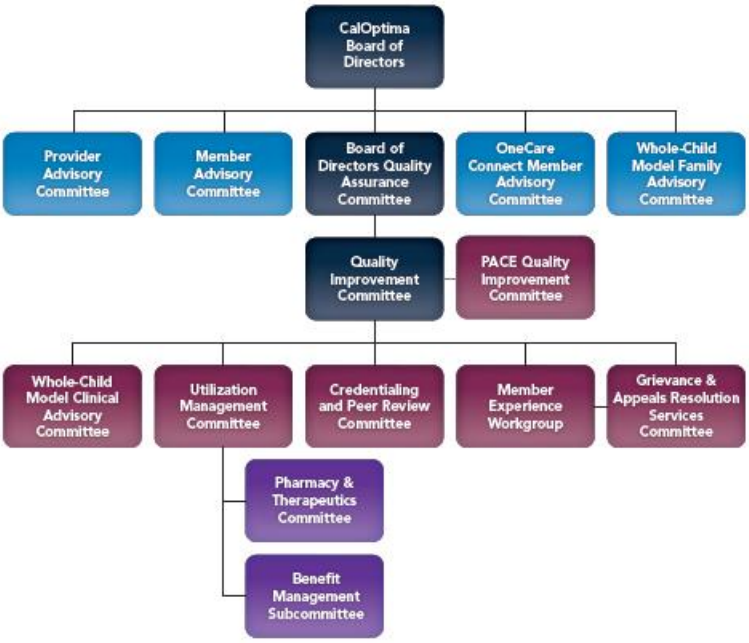
- CalOptima New Employee Orientation.
- HIPAA and Privacy/Corporate Compliance.
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.).
- UM Program, policies/procedures, etc.~~.~~
- MIS data entry.
- Application of Review Criteria/Guidelines.
- Appeals Process.
- Seniors and Persons with Disabilities Awareness Training.
- ~~OneCare~~ OC and ~~OneCare Connect~~OCC Training

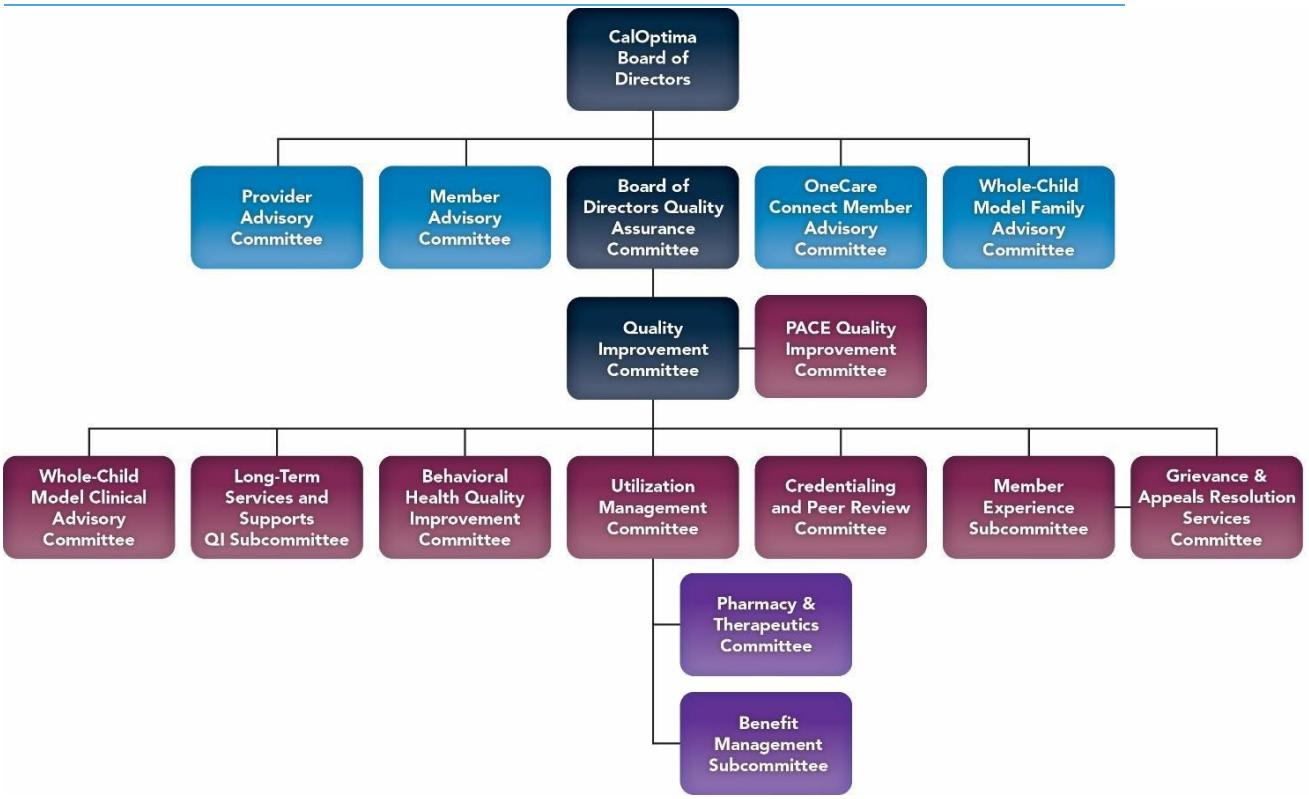
CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations using inter-rater reliability training and annual competency testing. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health professionals provide day-to-day supervise~~e~~ion of assigned UM staff, as well as oversight of - the UM process and all medical necessity decisions. The supervisor also participates in UM staff training to ensure understanding of UM concepts and practices and monitor for consistent application of criteria, for each level and type of UM decision. The supervisors perform monthly quality audits for each teammate who reports to them to monitor and ensure adequacy of documentation and consistent application of criteria. ~~A~~UM supervisors are available to UM staff either on site or telephone during normal business hours. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and ~~behavioral health~~BH benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure from the State of California. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients, is prohibited.- All medical management staff is required to sign an Affirmative Statement regarding this prohibition annually.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

2020 ~~COMMITTEE~~ Committee Organization ~~STRUCTURE~~Structure — Diagram





Utilization Management Committee (UMC)

The UM Committee (UMC) promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, and SRGs, and MBHOs to identify areas of under or over utilization that may adversely impact member care and is responsible for the annual review and approval of medical necessity criteria and protocols, the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as and Work Plan, and also reviews and approves the Annual UM Program Evaluation.

Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. With the assistance of the UM specialist, the director of UM maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses

of the above tracking and monitoring processes and the status of corrective action plans to the QIC. Oversight and operating authority of UM activities is delegated to the UMC which reports up ~~through CalOptima's~~to QIC and ultimately to ~~CalOptima's~~ QAC and the Board of Directors.

UMC Scope and Responsibilities

- Provides oversight and overall direction for the continuous improvement of the ~~utilization management~~UM program, consistent with CalOptima's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima and its delegated HN.
- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the ~~utilization management~~UM process.
- Reviews and approves the UM Program Description, Medical Necessity Criteria~~, UM Work Plan~~, UMC Charter and UM Program Evaluation on an annual basis.
- Reviews and analyzes UM Operational and Outcome data; ~~R~~reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
- Reviews and approves annual UM Metric targets and goals.
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promotes a high level of satisfaction with the UM program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, assesses, and recommends utilization management best practices used for selected diagnoses or disease classes.
- Conducts under/over utilization monitoring in accordance with UM Policy and Procedure GG.1532 Over and Under Utilization Monitoring; ~~sets appropriate upper and lower thresholds for over/under utilization trend reports.~~makes recommendations for improving performance on identified over-/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:

  Direct Subcommittee Reports:
  - Benefit Management Subcommittee (BMSC)
  - P&T

  Departments Reporting Relevant Information on UM Issues:
  - Delegation Oversight
  - Behavioral Health
  - Grievance and Appeals
  - UM Workgroup
  - LTSS
- Reports to the QIC on a quarterly basis; communicates significant findings and makes recommendations related to UM issues.

UMC Membership
Voting Members:

- CMO
- Medical Director UM
- Medical Director Behavioral Health*
- Medical Director Senior Programs
- Medical Director Quality and Analytics
- Executive Director, Clinical Operations
- Up to sSix participating practitioners from the community**

~~* Behavioral Health practitioner is defined as a medical director, clinical director, or participating practitioner from the organization or delegated provider groups.~~

** Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists, and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

The UMC is supported by:

- Director, UM
- Medical Director, Whole Child Model
- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

Benefit Management Subcommittee (BMSC)
The BMSC is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division (MMCD), All Plan Letters (APLs), and the Medi-Cal Manual.

BMSC Scope
The BMSC is responsible for the following:

- Maintaining a consistent benefit set for all lines of business.
- Revising and updating CalOptima's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility of the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Membership
~~The subcommittee membership consists of the following:~~

- Medical Director, Utilization Management- Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Claims Management
- Director, Claims
-

- Director, Coding Initiatives

The BMSC meets at least six times per year, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

~~Behavioral Health Quality Improvement Committee (BHQIC)~~

~~The purpose of the BHQIC is to:~~

~~Ensure members receive timely and satisfactory behavioral health care services.~~

~~Enhance the integration and coordination between physical health and behavioral health care providers.~~

~~Monitor key areas of service utilization by members and providers.~~

~~Identify areas of improvement.~~

~~Guide CalOptima towards the vision of bi-directional behavioral health care integration.~~

~~BHQIC Scope~~

~~The BHQIC responsibilities are to:~~

~~Ensure adequate provider availability and accessibility to effectively serve the membership.~~

~~Oversee the functions of delegated entities.~~

~~Monitor to ensure that care rendered is based on established clinical criteria, and clinical practice guidelines, and complies with regulatory and accrediting agency standards.~~

~~Ensure that member benefits and services are not underutilized, and that assessment and appropriate interventions are taken to identify inappropriate over utilization.~~

~~Utilize member and network provider satisfaction study results when implementing quality activities.~~

~~Maintain compliance with evolving NCQA accreditation standards.~~

~~Communicate results of clinical and service measures to network providers.~~

~~Document and report all monitoring activities to appropriate committees.~~

~~BHQIC Members~~

~~The designated chairman of the BHQIC is the Medical Director, Behavioral Health, who is responsible for reviewing information, reporting findings, and making QI recommendations, and represents the BHQIC at the QIC meetings. The voting members of the BHQIC include:~~

~~CMO~~

~~Executive Director, Clinical Operations~~

~~Medical Director, Behavioral Health Integration~~

~~Director of Behavioral Health Services~~

~~Medical Director, Medical Management~~

~~Medical Director, UM~~

~~Executive Director, Quality and Analytics~~

~~Medical Director, OC HCA~~

~~Medical Director, Managed Behavioral Health Organization~~

~~Medical Director, Health Network~~

~~Medical Director, Regional Center of Orange County~~

~~The committee may permit participation by other CalOptima staff or outside guests with relevant expertise and experience. The BHQIC meets quarterly at a minimum, and more frequently as needed.~~

~~LTSS Quality Improvement Subcommittee (LTSS QISC)~~

~~The LTSS QISC was created to provide a forum for LTSS providers to share best practices, identify challenges and barriers, and identify solutions that are person-centered, maximize available resources and reduce duplication of services.~~

~~The LTSS QISC Purpose~~

~~The purpose of the LTSS QISC is:~~

~~Engage stakeholders on strategies for integrating LTSS programs within the managed care delivery system.~~

~~Improve coordination of care for CalOptima members who reside in long-term care facilities and for those who receive Home- and Community-Based Services (HCBS).~~

~~The LTSS QISC Responsibilities~~

~~The LTSS QISC responsibilities are to:~~

~~Identify barriers to keeping members safe in their own homes or in the community, develop solutions, make appropriate recommendations to improve discharge planning process and prevent inappropriate admissions.~~

~~Evaluate the performance, success, and challenges of LTSS program providers of the following services: CBAS, MSSP and other HCBS.~~

~~Monitor the important aspects of quality of care, quality of services and patient safety by collecting and analyzing results.~~

~~Provide input on enhancing the capacity and coordination among LTSS providers, community-based organizations, housing providers, and managed care plans to care for individuals discharged from institutions.~~

~~Identify and recommend topics for LTSS provider workshops, educations and~~

~~trainings.~~

~~The LTSS QISC Structure~~

~~The designated chairman of the LTSS QISC is the Medical Director, Senior Programs, and the LTSS QISC invites the following participants:~~

~~Nursing Facility Administrators~~

~~CBAS Administrators~~

~~OC SSA, Deputy Director or Designee~~

~~MSSP, Site Director or Designee~~

~~CMO~~

~~Medical Director, QI and Analytics~~

~~Medical Director, UM~~

~~Executive Director, Clinical Operations~~

~~Executive Director, Quality Analytics~~

~~Manager(s), LTSS~~

~~Director, LTSS~~

~~The LTSS QISC meets at least quarterly, and as needed.~~

~~INTEGRATION WITH THE QUALITY IMPROVEMENT PROGRAM~~Integration with the QI Program

The UM Program ~~and Work Plan are~~ is evaluated and submitted for review and approval annually by ~~the CalOptima~~ UMC, ~~the~~ QIC and ~~the~~ QAC, with final review and approval by the Board of Directors.

- The UM program is evaluated, revised and prepared for approval by the UM Director in conjunction with the Executive Director of Clinical Services, Chief Medical Officer, Deputy Chief Medical Director and Utilization Management Medical Director prior to submission for committee review and approval.
- Utilization data is collected, aggregated and analyzed including, but not limited to, denials, unused authorizations, provider preventable conditions, and trends representing potential over or under utilization.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization review activities. These issues are referred to the QI staff for evaluation.
- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.
- The QIC reports to the Board QAC.

Integration with Other Processes

The UM Program, Case Management Program, BH Program, Managed LTSS Programs, P&T, QI, Credentialing, Compliance, and Audit and Oversight are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to the QI department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate

potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. CalOptima requires that all individuals who serve on UMC or who otherwise make decisions on ~~utilization management~~UM, quality oversight and activities, timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.

This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QIC and the subcommittees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All

information is maintained in confidential files. The HMOs, PHCs, and SRGs ~~and Managed Behavioral Health Organizations (MBHOs)~~ hold all information in the strictest confidence. Members of the QIC and the subcommittees sign a Confidentiality Agreement. This agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the State Contract.

~~Integration With Other Processes~~

~~The UM Program, Case Management Program, Behavioral Health Program, Managed LTSS Programs, P&T Committee~~~~, Quality Improvement, Credentialing, Compliance, and Audit and Oversight are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to~~ **~~CalOptima's QI department. As case managers perform the~~** ~~functions of UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the u~~**~~tilization of services is inter-related with the quality and outcome of the services.~~**

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~~Early childhood intervention~~
~~State protective and regulatory services~~
~~Women, Infant and Children Services (WIC)~~
~~EPSDT Health Check~~
~~Services provided by local public health departments~~

UM PROCESS

The UM process encompasses the following program components: referral/prior authorization, concurrent review, post-stabilization services, ambulatory review, retrospective review, discharge planning and care coordination~~,~~ and second opinions. All approved services must meet medical necessity criteria.~~.~~ The clinical decision process begins when a request for authorization of service is received. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, or scheduled inpatient services. The process is complete when the requesting ~~practitione~~practitioner ~~r~~

and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified.

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the DHCS and ~~the Centers for Medicare and Medicaid Services (~~CMS~~)~~. A variety of program documents, regulations, policy letters and all CMS benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the ~~CalOptima~~ Audit and Oversight department via its delegation oversight team for compliance.

~~UM Program Structure~~

~~The UM Program is designed to work collaboratively with delegated entities, including, but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community in an effort to assure that the member receives appropriate, cost efficient, quality- based health care.~~

~~The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of CMS, DHCS, DMHC, CDA and NCQA at least annually. Recommendations for revisions and improvements are made, as appropriate. The UM Work Plan is based on the findings of the annual program Work Plan evaluation. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network.~~

~~Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization.~~

~~The organization chart and the UM p~~Program~~'s C~~committee~~'s reporting structure accurately reflect CalOptima's ~~the~~ Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the UMC and QIC, which serve as the oversight committees for CalOptima UM functions, are contained and delineated in the C~~committee~~'s C~~harters.~~

~~The CalOptima UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer; Deputy Chief Medical Officer; Medical Director(s) of UM; Executive Director, Clinical Operations; UMC; and QIC. CalOptima-contracted delegates are delegated UM responsibilities, including the UM Program and UM Work Plan.~~

R~~EVIEW~~EVIEW ~~AND~~AND A~~UTHORIZATION~~UTHORIZATION ~~OF~~OF S~~ERVICES~~ERVICES

Medical Necessity Review

Medical necessity review requires consideration of the members' circumstances, relative to appropriate clinical criteria and CalOptima policies, applying current evidence-based guidelines, and consideration of available services within the local delivery system. These decisions are consistent with current evidence-based clinical practice guidelines.

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with ~~the Centers for Medicare and Medicaid Services~~CMS and the State of California for Medi-Cal, OC and OCC. Medically necessary means ~~all covered services or supplies that~~:

- For Medi-Cal, covered services that a~~A~~re reasonable and necessary to protect life, 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, maintain, or regain functional capacity. ;For Medi-Cal members receiving MLTSS, medical necessity is determined in accordance with member's current needs assessment and consistent with person-centered planning. When determining the medical necessity for Medi-Cal member 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 sections 14132(v).
  - ~~Meet the standards of good medical practice in the local area;~~
  - ~~Are consistent with current evidence-based clinical practice guidelines; and .~~
- ~~Are not mainly for the convenience of the member or the doctor.~~
- For Medicare, covered services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C section 1395y.

The CalOptima UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost-efficient manner, without compromising quality. Physicians, or pharmacists or psychologists in ~~other~~ appropriate ~~health care~~situations, ~~professionals,~~ review and determine all final denial or modification decisions for requested medical and ~~behavioral health~~BH care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified ~~P~~physician or ~~P~~pharmacist.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Admission Review
- Post-stabilization inpatient review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for health network members

The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications~~,~~ or termination of services.
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed~~,~~ and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological situation

    - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action per CalOptima Policy and Procedure GG.1508, Authorization and Processing of Referrals.
- Reasons for decisions are clearly documented in the medical management system, including criteria used to make the determination.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time frames, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services.
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.
- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- All members are notified in writing of any decision to deny, modify, or delay a service authorization request.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director (~~or~~ Peer-to-Peer)~~,~~ or a copy of the specific criteria utilized.

The information that may be used to make medical necessity determinations includes, but is not ––limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information

- Information from responsible family members

~~CalOptima's~~ UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director, Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Prior Authorization

Prior authorization requires the provider or practitioner to submit a formal medical necessity determination request and all relevant clinical information related to the request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the CalOptima website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Link system allows for non-urgent on-line authorizations to be submitted by providers and processed electronically. Some referrals are auto -adjudicated through referral intelligence rules (RIR). Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone based on the urgency of the request.

Referrals

A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. PCPs are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians, as noted on the Prior Authorization Required List, and all non-emergency out-of- network practitioners

~~t.~~

Second Opinions

A second opinion may be requested when there is a question concerning diagnosis or options for

surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of- network practitioner, if there is no in--network practitioner available.

Extended Specialist Services
Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "Standing Referral" policy and procedure, Standing Referral: GG.1112, includes guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers
If a member or provider requires or requests a provider out-of-network for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise, and complexity of the case.

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice, and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima distributes an affirmative statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima does not specifically reward practitioners or other individuals for issuing denials of coverage. ~~members by UM decision makers~~CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

PHARMACEUTICAL MANAGEMENT

Pharmacy Management is overseen by the CMO, and CalOptima's Director, Pharmacy. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by ~~the~~ P&T ~~Committee~~ and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima website.

~~pharmaceutical information becomes available.~~
~~Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima website.~~

The ~~CalOptima~~ P&T ~~Committee~~ is responsible for development of the CalOptima Approved Drug List (Formulary), which is based on sound clinical evidence, and is reviewed at least annually by ~~actively~~ practicing practitioners and pharmacists. Updates to the CalOptima Approved Drug List are communicated to both members and providers. If the following situations exist, CalOptima evaluates the appropriateness of prior authorization of non-formulary drugs:

- No formulary alternative is appropriate, and the drug is medically necessary.
- The member has failed treatment or experienced adverse effects on the formulary drug.
- The member's treatment has been stable on a non-formulary drug and change to a formulary drug is medically inappropriate.

To request prior authorization for outpatient medications not on the CalOptima Formulary, the physician or physician's agent must provide documentation to support the request for coverage. Documentation is provided via the CalOptima Pharmacy Prior Authorization (PA) form, which is faxed to CalOptima's PBM for review. All potential authorization denials are reviewed by a ~~P~~pharmacist at CalOptima, as per DHCS requirements. The Pharmacy Management department profiles drug utilization by members to identify instances of polypharmacy that may pose a health risk to the member. Medication profiles for members receiving multiple medication fills per month are reviewed by a ~~C~~clinical ~~P~~pharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over-utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

P~~HARMACY~~harmacy D~~ETERMINATIONS~~eterminations

Medi-Cal
CalOptima's Pharmacy Management department delegates initial prior authorization review to the PBM based on clinical prior authorization criteria developed by the CalOptima Pharmacy Management staff and approved by the ~~CalOptima~~ P&T ~~Committee~~. The PBM may approve or defer for additional information, but final denial and appeal determinations may only be made by a CalOptima pharmacist or Medical Director. In addition, final decisions for requests that are outside of the available criteria must be made by a CalOptima pharmacist or Medical Director. CalOptima's written notification of pharmacy denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss pharmacy UM denial decisions.

OC/OCC
CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Formulary
The CalOptima drug Formularies were created to offer a core list of preferred medications to all practitioners. Local providers may make requests to review specific drugs for addition to the Formulary. The Formulary is developed and maintained by the ~~CalOptima~~ P&T ~~Committee~~. Final approval from the P&T ~~Committee~~ must be received to add drugs to the Formulary. The CalOptima Formularies are available on the CalOptima website or in hard copy upon request.

Pharmacy Benefit Manager
The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, ~~customer service,~~ pharmacy help desk, prior authorization, clinical services and quality improvement functions. ~~The PBM recommends denial decisions based on lack of medical necessity, drugs not included in the Formulary, prior authorization not obtained, etc.~~ The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity the PBM is monitored according to the Audit and Oversight department's policies and procedures.

B~~EHAVIORAL~~EHAVIORAL H~~EALTH~~EALTH D~~ETERMINATIONS~~ETERMINATIONS

Medi-Cal
CalOptima's ~~Behavioral Health Integration~~BHI department performs prior authorization review for BHT services and psychological testing. Prior authorization requests are reviewed by ~~behavioral health~~BH UM staff that consist of Medical Case Managers and Care Managers (BCBA).

Determinations are based on criteria from MCG Guidelines, APL, and CalOptima policy (approved by DHCS).

OC/OCC
CalOptima has previously delegated Magellan Health Inc. to directly manage the behavioral health utilization management functions for OneCare/OneCare Connect. Effective ~~1/1/~~January 1, 2020, CalOptima's ~~Behavioral Health Integration~~BHI ~~D~~department will perform prior authorization review functions for OC/OCC covered behavioral health services. -Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program, and psychological testing. -Prior authorization requests are reviewed by ~~behavioral health~~BH Medical Case Managers. -Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL), and CalOptima policies.

The ~~behavioral health~~BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may only be made by a Licensed CalOptima ~~Licensed~~ Psychologist or Medical Director. CalOptima's written notification of ~~behavioral health~~BH modifications and denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments,

documents or other information relevant to the appeal.

- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent

denials.

- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss ~~behavioral health~~BH UM denial decisions.

~~OC/OCC~~

~~CalOptima delegates Magellan Health Inc. to directly manage the behavioral health utilization management functions for OneCare/OneCare Connect. Magellan complies with regulatory timelines and criteria set forth by MCG guidelines, APL's, and CalOptima Policies (approved by CMS).~~

UM C~~RITERIA~~RITERIA

CalOptima conducts Utilization Review using UM criteria that are nationally recognized, evidence-based standards of care and include input from recognized experts in the development, ~~adaption~~ adoption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Such criteria and guidelines include, but are not limited to:

MEDIedi-CALal

1. Federal and Sstate lLaw Mmandates (i.e. Centers for Medicare and MedicaidS, Department of HealthCare ServicesDHCS);
2. Medi-Cal Manual of Criteria/ and Medi-Cal Benefits Guidelines
3. EPSDT
4. Nationally recognized Eevidence Bbased criteria such as Milliman Care Guidelines (MCG), –U.S. ®Preventative Services Task Force Recommendations, and National Comprehensive Cancer Guidelines, etc.
5. Transplant Centers of Excellence guidelines
6. Preventive health/ and/or Ssociety guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology ([ACOG] Guidelines), American Medical Association (AMA), and National Guidelines Clearinghouse)
   - BHCalOptima Policy & Procedures and/or Clinical Benefits & Guidelines
7.

WHOLEhole CHILDhild MODELodel (MEDI-CAL)

In addition to the Medi-Cal hierarchy above:

- CCS Numbered Letters (N.L.s) and county CCS Program Information Notices for decisions related to CCS and Whole Child Model.

1.

MEDICAREedicare (OneCare and OneCare Connect)

For OC and OCC:

1. Federal and Sstate Llaw Mmandates (i.e. Centers for MDedicare and Medicaid, Department of HealthCare ServicesDHCS);
2. CMS Guidelines Local and National Coverage Determinations (LCD, NCD);
3. Medicare Part D: CMS-approved Compendia (for medications)
4. Medi-Cal Manual of Criteria/ and Medi-Cal Benefits Guidelines
5. Nationally recognized Eevidence Bbased criteria such as MCG, UpToDate, U.S. Preventative Services Task Force Recommendations, and National Comprehensive Cancer Guidelines, etc.
6. Transplant Centers of Excellence guidelines
7. Preventive health and/or /sSociety guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG Guidelines,) American Medical Association, National Guidelines Clearinghouse)
8. CalOptima Policy & Procedures and/or Clinical Benefits & Guidelines

- Nationally recognized Evidence Based criteria such as Milliman Care Guidelines (MCG)
- Medicare and Medi-Cal Manuals of Criteria
- Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) guidelines
- Medicare Part D: CMS-approved Compendia
- National Guideline Clearinghouse
- National Comprehensive Cancer Network (NCCN) Guidelines
- Transplant Centers of Excellence guidelines
- Preventive health guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG Guidelines)
- CalOptima Criteria for outpatient behavioral health services
- CalOptima Policies and Medi-Cal Benefits Guidelines

- ~~Beginning July 1, 2019, or such later time as CalOptima assume responsibility for the provision of CCS services for its members, CCS Numbered Letters (N.L.s) and county CCS Program Information Notices for decisions related to CCS and Whole Child Model.~~

Delegated ~~health network~~HNs must utilize the same or similar nationally recognized criteria.

Due to the dynamic state of medical/health care practices, each medical decision must be case- specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes,

Lead Screening, Immunizations, and ADHD/ADD ~~G~~guidelines for both adults and children.

Authorization Types

~~Review Roles~~

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	~~PA~~ UM Nurse Reviewer**	Medical Director/ ~~/~~Physician Reviewer (Denials and Modifications)
Chemotherapy – all request types reviewed by Pharmacy ~~D~~department	MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines			X
DME (Custom & Standard)	MCG / Medi-Cal and Medicare Manuals		X	X
Diagnostics	MCG / Medi-Cal and Medicare Manuals		X	X
Hearing Aids	Medi-Cal and Medicare Manuals	X	X	X
Home Health	MCG / Medi-Cal and Medicare Manuals		X	X
Imaging	MCG / Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals	X	X	X
Injectables	MCG / Medi-Cal and Medicare Manuals		X	X
Inpatient hospital services	MCG / Medi-Cal and Medicare Manuals		X	X
Medical Supplies (DME Related)	MCG / Medi-Cal and Medicare Manuals	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	MCG / Medi-Cal and Medicare Manuals		X	X
Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG / Medi-Cal and Medicare Manuals		X	X
Prosthetics	MCG / Medi-Cal and Medicare Manuals		X	X
Radiation Oncology	MCG / Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	MCG / Medi-Cal and Medicare Manuals		X	

Transplants	DHCS Guidelines/ MCG		X	X

* If Medical Necessity criteria is not met, the request is referred to a ~~PA~~UM Nurse Reviewer for further review and determination.
** If Medical Necessity criteria is not met, the request is referred to a Medical Director/Physician Reviewer for further review and determination.

~~Authorization Type*~~	~~Criteria Utilized~~	~~Medical Authorization Assistant*~~	~~PA Nurse Reviewer**~~	~~Medical Director /Physician Reviewer (Denials and Modifications)~~
~~Transplants~~	~~DHCS Guidelines/ MCG~~		~~X~~	~~X~~

~~* If Medical Necessity criteria is not met, the request is referred to a PA Nurse Reviewer for further review and determination.~~
~~** If Medical Necessity criteria is not met, the request is referred to a Medical Director / Physician Reviewer for further review and determination.~~

~~Long-Term Support Services Authorization Types~~Long-Term Support Services

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer (Denials and Modifications)
Community-Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		**X**	**X**
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51335		**X**	**X**
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51334		**X**	**X**
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Sections 51003 and 51303		**X**	**X**
Long-Term Care: Intermediate Care Facility / Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Sections 51343 and 51164	**X** DDS or DMH Certified	**X**	**X**
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

~~Medi-Cal~~ Behavioral Health Services ~~Authorization Types~~

Authorization Type*	Criteria Utilized	Medical Case Manager	Care Manager (BCBA)	Medical Physician Reviewer / Licensed Psychologist
Psychological Testing	Title 22, MCG, Medi-Cal and Medicare Manuals, CalOptima policy	**X**		**X**
Behavioral Health Treatment (BHT) services (Medi-Cal only)	Title 22, WIC Section 14132, MCG, H&S Code 1374.73, Medi-Cal Manual, CalOptima policy DHCS APL 18-006	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Physician Reviewer/Licensed Psychologist for review and determination.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service, ~~behavioral or~~health BH, or certain appeal reviews, the clinical judgment needed for a~~n~~ UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified ~~behavioral health~~BH professionals as determined by the Medical ~~Director, for~~Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

~~For the purposes of Behavioral Health review and oversight as a delegated vendor, Magellan ensures there are peer reviewers/clinical consultants. Peer reviewers are behavioral health professionals who are qualified, as determined by Magellan's Medical Director, to render a clinical opinion about the behavioral health condition, procedure, and/or treatment under review. Peer reviewers must hold a current unrestricted California license to practice medicine in the appropriate specialty to render an opinion about whether a requested service meets established medical necessity criteria.~~

New Technology Review

~~Medi-Cal, OC and OCC~~

~~CalOptima's~~ The P&T ~~Committee~~ and ~~Benefit Management subcommittee~~BMSC shall study the medical, social, ethical, and economic implications of new technologies in order to evaluate the safety and efficacy of use for members, in accordance with CalOptima Policy GG.1534 Evaluation of New Technology and Uses.

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting ~~CalOptima's~~ the UM department or may discuss the UM decision

with CalOptima Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-service to review all required provider trainings, including operational and clinical information such as, UM timeliness of decisions. In addition, Provider Relations also provides any related policies with regard to UM timeliness of decisions. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability ~~(IRR)~~

At least annually, the CMO and Executive Director, Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director,
Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, ~~CalOptima's~~ UM leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight.~~-~~ The IRR is reported to the UMC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from the committee.

Provider~~/~~ and Member Communication

Members and practitioners can access UM staff through a toll-free telephone number **888-587-8088** at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. ~~TDD/~~TTY services for deaf, hard of hearing or speech impaired members are available toll free at **800-735-2929**. The phone numbers for these are included in the Member Handbook, on the CalOptima website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services.

Inbound and outbound communications may include directly speaking with practitioners and members, ~~or~~ faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima or notifies CalOptima on-call nurse in cases requiring immediate response. A log is forwarded to the UM department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer

The CalOptima Medical Director or appropriate practitioner reviewer (~~behavioral health~~BH and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation~~,~~ and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling ~~CalOptima's main toll-~~

free phone number and asking for the CalOptima Medical Directorthe direct dial number for the Medical Director at the bottom of the provider denial notification. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner. -Whenever a peer-to-peer request is made, documentation is added to the denied referral within Guiding Care, our UM system.

UM Staff Access to Clinical Expertise

The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, with the support of the UMC, have the authority, accountability and responsibility for denial determinations. For those contracted delegated HNs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records

UM staff does not routinely request copies of medical records on all patients reviewed. During prospective and concurrent telephonic review, copies of medical records are only required to validate medical necessity for the requested service.- when difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay during a verbal review. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information

CalOptima's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g. discharge planning, case management, disease management, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider/ Communication to Member Communication

CalOptima's UM program in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or absence of treatment.
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- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
-

TIMELINESS TIMELINESS OFOF UM DECISIONSECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for

providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

UM Decision and Notification Timelines —

Medi-Cal (Excludes Pharmacy Requests)

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Routine (Non-Urgent) Pre-Service: Prospective or concurrent service requests where no extension is requested or needed	Approve, modify or deny within 5 working days of receipt of "all information" reasonably necessary and requested to render a decision, and in all circumstances ~~but~~ no later ~~longer~~ than 14 calendar days following receipt of request. "A~~a~~ll information" means: Service requested (CPT/HCPC code and description), complete clinical information from any external entity necessary to provide an accurate clinical presentation	**Practitioner:** Within 24 hours of the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Dated and postmarked within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.

Routine (Non-Urgent) Pre-Service **Extension Needed** (AKA: Deferral) • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed	Due to a lack of information, for an additional 14 calendar days, under the following conditions: ▪ The member or the member's provider may request for an extension, or the plan can provide justification upon request by the ~~S~~state for the need for additional information and how it is in the member's interest. The delay notice shall include the additional information needed to render the decision, the type of expert needed to review, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.	**Practitioner:** Within 24 hours of the decision, not to exceed 14 calendar days from the receipt of the request	**Practitioner:** Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request. **Member:** Dated and postmarked within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request **Note:** CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	Additional Requested Information is Received: A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. **Additional information incomplete or not received:** If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.		
Expedited Authorization Requests (Pre-Service): No extension requested or needed. All necessary information received at time of initial request. Requests where a provider indicates, or the plan determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain	Approve, modify or deny within 72 hours from receipt of request	**Practitioner:** Within 24 hours of making the decision, not to exceed 72 hours from receipt of the request.	**Practitioner:** Within 72 hours of the request. **Member:** Postmarked and mailed within 72 hours from receipt of the request.
Expedited Authorization (Pre-Service) — ~~Extension~~ Extension needed: Extension is allowed ***only*** if member or provider requests the extension or the plan justifies the need for additional information and is able to demonstrate how the delay is in the	The plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: ▪ Within 24 hours of receipt of the urgent preservice request, the plan asks the member, the member's representative, or provider for the specific information necessary to make the decision.	**Practitioner and Member:** Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.	**Practitioner**: Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	▪ The plan gives the member or member's authorized representative at least 48 hours to provide the information. ▪ The extension period, within which a decision must be made by the plan, begins: ○ On the date when the plan receives the member's response (even if not all of the information is provided), ***or*** ○ At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.		**Member:** Within 2 business days of the ~~decision[2] but~~decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination[3] (written notification) **Note:** CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.
	Expedited (Urgent) Pre-Service request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for services where application of the time frame for making routine or non-life-threatening care determinations: ○ Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or ○ In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Within 2 working days of making the decision

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	○ The member or the member's provider may request for an extension, or the health plan/provider group can provide justification upon request by the state for the need for additional information and how it is in the member's interest. ○ Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. ○ Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.		
Concurrent: Concurrent review of treatment regimen already in place, even if the health plan did not previously approve the earlier care (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of the health plan's decision, and a care plan has been agreed	Within 24 hours of receipt of the request **NOTE:** The plan may extend decision time frame if the request to approve additional days for urgent concurrent care is related to care not approved by the plan previously; the plan documents that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to. The plan has up to 72 hours to make a	**Practitioner and Member:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision **Member:** Within 24 hours of making the decision For terminations, suspensions, or reductions of previously authorized services, the plan must notify beneficiaries at least 10 days before the date of the action with the exception of circumstances

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
upon by the treating provider that is appropriate for the medical needs of that member	decision (NCQA UM 5). ○ A response to defer is required within 24 hours for all services that require prior authorization. ○ A decision to approve, modify, or deny is required within 72 hours, or as soon as a member's health condition requires, after the receipt of the request. ○ If the plan is unable to request for an extension of an urgent concurrent care within 24 hours before the expiration of the prescribed period of time or number of treatments, then the plan may treat the request as urgent preservice and make a decision within 72 hours. The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny.		permitted under Title 42, CFR, Sections 431.213 and 431.214.
Post-Service / Retrospective Review: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination (written notification) **Member:** Within 2 business days of the decision [2] but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Post-Service: Extension needed Additional clinical information required	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request. **Additional Information Received:** If requested information is received, decision must be made within 30 calendar days from receipt of request for information. **Additional Clinical Information Incomplete or Not Received:** Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	**Member & Practitioner**: None specified **Member & Practitioner**: None specified **Member & Practitioner**: None specified	**Practitioner / Member:** For ALL Decision Types: Written notice within 30 calendar days from receipt of the information necessary to make the determination.
Hospice - Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Within 24 hours of making the decision **Member:** None Specified	**Practitioner / Member:** Written notice within 2 working days or making the decision.

~~UM Decision and Notification Timelines —~~ Medicare (Excludes Pharmacy Requests)

Type of Request	Decision	Notification Timeframe Member and Practitioner
Standard Initial Organization Determination (Pre-Service) If no extension requested or needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) If extension requested or needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	***Extension Notice:*** Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: The reasons for the delay The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The health plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** Must occur no later than expiration of extension.
Expedited Initial Organization Determination If expedited criteria are not met	Promptly decide whether to expedite — determine if: 1. Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2. If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. o If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14-day period begins with the day the request was	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. The written notice must include: 1. Explain that the health plan will automatically transfer and process the request using the 14-day timeframe for standard determinations. 2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	received for an expedited determination.	4. Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination If no extension requested or needed	As soon as medically necessary, within 72 hours after receipt of request (includes weekends and holidays).	Within 72 hours after receipt of request. ▪ **Approvals** ○ Oral or written notice must be given to member and provider within 72 hours of receipt of request. ○ Document date and time oral notice is given. ○ If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** ○ When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. ○ Document date and time of oral notice. ○ If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request.
Expedited Initial Organization Determination If extension requested or needed	May extend up to 14 calendar days. Note: Extension allowed only if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers. ▪ When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request).	***Extension Notice:*** Give notice in writing, within 72 hours of receipt of request. The extension notice must include: ▪ The reasons for the delay ▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. ▪ Note: The health plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification*** After an Extension: ▪ Approvals ○ Oral or written notice must be given to member and provider no later than upon expiration of extension. ○ Document date and time oral notice is given. If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. ▪ Denials ○ When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. ○ Document date and time of oral notice. ○ If only written notice is given, it must be received by member and provider no later

Type of Request	Decision	Notification Timeframe Member and Practitioner
	▪ Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	than upon expiration of extension.

~~UM Decisions and Timeframes for Determinations —~~ Pharmacy for Medi-Cal, OC~~C~~ & OCC

Medi-Cal Pharmaceutical — Decision Making	O~~ne~~C~~are~~ and O~~ne~~C~~are~~ C~~onnect~~ Pharmaceutical — Decision Making
• Processed by CalOptima Pharmacy Management department or Pharmacy Benefits Manager • Qualified pharmacist or physician review for any modifications or denials • Qualified physician review for any appeals	• Processed by CalOptima Pharmacy Management department • Qualified pharmacist or physician review for any modifications or denials • Qualified physician review for any appeals

Medi-Cal Pharmacy Timeframes for Determinations	O~~ne~~C~~are~~ and O~~ne~~C~~are~~ C~~onnect~~ Pharmacy Timeframes for Determinations (Part D):
Standard (Non-urgent) Preservice: Within 24 hours a decision to approve, modify, deny or defer is required. **Standard (Non-urgent) Preservice, Extension Needed:** Within 5 working days of receiving needed information, but no longer than 14 calendar days **Expedited (Urgent) Preservice/Concurr~~r~~ent:** Within 24 hours a decision to approve, modify, deny or defer is required. **Expedited (Urgent) Preservice/Concurrent, Extension Needed:** Within 72 hours of the initial request ~~**Concurrent:** A deferral must be made within 24 hours if indicated. Approval, modification or denial within 72 hours.~~ **Post-Service/Retrospective:** Within 30 days of receipt	• Routine: 72 hours • Urgent: 24 hours • Retrospective: 14 days

Medi-Cal Pharmacy Timeframes for Notification	OneCare and OneCare Connect Pharmacy Timeframes for Notification (Part D)
~~Routine (Non-Urgent):~~ **Pre-Service** and Concurrent Approvals: ~~Extension Needed:~~ Provider: Electronic/written: Within 24 ~~business hours~~days of making the decision~~, not to exceed 14 calendar days from the receipt of request~~. ~~Member: Written: Within 2 business days of the decision, not to exceed 14 calendar days from the receipt of request.~~ **Pre-Service and Concurrent Denials:** Provider: Electronic/written: Within 24 hours of making the decision. Member: Written: Within 2 business days of making the decision. ~~**Expedited Authorization (Pre-Service):**~~ ~~Notification of Denial or Modification:~~ ~~Provider: Electronic/written: Within 2 business days of making the decision.~~ ~~Member: Written: Within 2 business days of making the decision.~~ ~~**Expedited (Urgent) Preservice, Extension Needed:**~~ ~~Provider: Electronic/written: Within 2 business days of the decision~~ ~~Member: Written: Within 2 business days of the decision~~ ~~**Concurrent:**~~ ~~Provider: Electronic/written: Within 24 hours of making the decision.~~ ~~Member: Written: Within 24 hours of making the decision.~~ **Post Service/ Retrospective Approvals~~Review~~:** Practitioner: Written: Within 30 days of receipt of request. ~~Member: Written: Within 30 days of receipt of request.~~ **Post Service/ Retrospective Denials:** Practitioner: Written: Within 30 days of receipt of request. Member: Written: Within 30 days of receipt of request.	Authorization Request Type: **For expedited requests**: Written notification must be provided to the member within 24 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification. **For standard requests**: Written notification must be provided to the member within 72 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification. **For retrospective requests:** Written notification must be provided to the member within 14 calendar days from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.

Emergency Services

Emergency room services are available 24 hours ~~a/ day~~per day, 7 days ~~a/ week~~per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition. CalOptima covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Services

A ~~H~~hospital must submit a Prior Authorization Request for Post-Stabilization Services when a ~~M~~member who has received ~~E~~emergency ~~S~~services for an ~~E~~emergency ~~M~~medical ~~C~~condition is determined to have reached medical stability, but requires additional, ~~M~~medically ~~N~~necessary inpatient covered services that are related to the ~~E~~emergency ~~M~~medical ~~C~~condition, and provided to maintain, improve or resolve the ~~M~~member's stabilized medical condition.

CalOptima or a H~~ealth N~~~~etwork~~ shall approve or deny within 30 minutes after receiving a ~~the~~ p~~P~~rior a~~A~~uthorization r~~R~~equest for p~~P~~ost- s~~S~~tabilization ~~S~~services and all information reasonably necessary and requested to render a decision from a hospital for Medi-Cal members, ~~within 30 minutes of receipt of the telephone call from the H~~hospital for Medi- Cal members, and within 60 minutes ~~of receipt~~after ~~of~~ receiving such request and information ~~the telephone call~~ from ~~the~~ a hospital for O~~ne~~C~~are~~ or O~~ne~~C~~are C~~~~onnect~~ members. If CalOptima or the HN does not respond within the prescribed time frame, ~~M~~medically ~~N~~necessary post-stabilization services are considered approved.

~~Although CalOptima may establish guidelines and timelines for submittal of notification regarding the provision of emergency services, including emergent admissions, CalOptima does not refuse to cover an emergency service based on the practitioner's or the facility's failure to notify CalOptima of the screening and treatment within the required time frames, except as related to any claim filing time frames. Members who have an emergency medical condition are not required to pay for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.~~

~~PRIOR~~ PRIOR ~~AUTHORIZATION~~ AUTHORIZATION ~~SERVICES~~SERVICES

UM Urgent/Expedited Prior Authorization Services

For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima at least 5 days prior to the requested service date. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. Prior authorization is never required for emergency or urgent care services.

UM Routine/Standard Prior Authorization Services

CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within 5 business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request for Medi-Cal members and within 14 calendar days for OC/OCC.

Retrospective Review

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director, UM or designee, reviews the request for retrospective authorization. Retrospective Authorization shall only be permitted in accordance with CalOptima Policy and Procedure GG.15008 Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers~~Authorization and Processing of Referrals~~.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director, UM or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Concurrent Review Process

In addition to authorization for post-stabilization services that often result in an inpatient admission, f~~F~~acilities are also required to notify CalOptima of all inpatient admissions within 1 business day following the admission. The admission/concurrent review process assesses the clinical status of the member, verifies the need for continued hospitalization, facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed

- Validating the diagnosis
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures proposed
- Reasons for extension of the treatment or service

A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously_

approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre- service and post-service).

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonically. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment, and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight certified mail to the attending physician, hospital and the member.

The need for case management or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima QI department for investigation and resolution.

~~Hospitalist/SNFist Program~~

~~The goal of the Hospitalist/SNFist Program is for early identification and management of members, either in the Emergency Room or inpatient setting, with prompt linkage to an identified hospitalist/SNFist to ensure that the member receives the appropriate care in the most appropriate setting. Appropriate setting is determined by medical providers using established evidence based clinical and administrative criteria. Other program objectives include:~~

~~Initiate appropriate care plan consistent with:~~

- ~~Established estimated length of stay criteria.~~
- ~~Medical necessity criteria to establish appropriate level of care.~~
- ~~Member psychosocial needs impacting ongoing care.~~
- ~~Communication of current and ongoing needs impacting discharge planning and after-care requirements to PCP and others involved in the members care.~~
- ~~Facilitation of transfer of members from non-contracted facilities to facilities with a contracted hospitalist team.~~

~~Contracted hospitalist groups, facilities case management staff, and Emergency Room personnel receive training from CalOptima staff on:~~

- ~~Early identification of COD members~~
- ~~Process for notification of hospitalists~~
- ~~Face sheet and/or telephonic notification to CalOptima~~
- ~~Care plan development and implementation~~
- ~~Discharge planning~~

~~The role of the hospitalist is to work together with the Emergency Department team to determine the optimal location and level of care for the member's treatment needs. If, based on clinical information and medical necessity criteria, the member requires admission to the facility; the hospitalist assumes primary responsibility for the member's care as the admitting physician and will coordinate the member's care together with CalOptima medical management staff. If at any time the member is appropriate for transfer to a lower level of care, whether directly from the emergency room or after admission, the hospitalist will facilitate the transfer to the appropriate setting, in concert with the accepting facility and with CalOptima staff.~~

Discharge Planning Review

Discharge planning begins within 48 hours of an inpatient admission and is designed to identify and initiate a cost effective, quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member's care.
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Concurrent Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial or termination of any service based on medical necessity or benefit limitations. Upon any adverse determination for medical or behavioral health services made by a CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the time frames as noted in GG.1508 Authorization and Processing of Referrals~~the Referral/Authorization~~

~~Processing Policy and Procedure~~. The written notification is written in lay language that is easily understandable at the 6th~~th~~ grade level and includes the member specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and time frames for appeal of the decision. All templates for written notifications of decision making are DHCS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Medical Director or appropriate practitioner reviewer (~~behavioral health~~BH practitioner, pharmacist, etc.) serves as the point of contact for the peer to peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

~~GRIEVANCE~~ GRIEVANCE AND APPEAL ~~PROCESS~~PROCESS

CalOptima has a comprehensive review system to address matters when Medi-Cal, O~~ne~~C~~are~~ or O~~ne~~C~~are~~ C~~onnect~~ members wish to exercise their right to review a UM decision to deny, delay, or modify a request for services, or terminate a previously-approved service. This process is initiated by contact from a member, a member's representative, or practitioner to CalOptima. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima's Gri~~e~~evance and Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.
The grievance process is in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint. ~~-~~The appeal process is in accordance with ~~and~~ CalOptima Policy GG.1510: Appeal Process. This process includes:

- Collection of ~~data.~~ information and/or medical records related to the grievance or appeal.
- Communication to the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.~~.~~
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for COD, HMOs, PHCs and SRGs is handled by CalOptima GARS. CalOptima works collaboratively with the delegated entity in the gathering of information and supporting documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the California Department of Social Services. Grievances and appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer, other than the reviewer who made the initial denial determination. The UM or CM Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The UM ~~-~~or CM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a

Board-

Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

Upon request, members can have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Customer Service department.

Expedited Grievances

A member, ~~-~~member's authorized representative or provider may request the grievance or appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt.

At the time of the request, the information is reviewed, and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality.

State Hearing ~~(Medi-Cal Line of Business Only)~~

CalOptima Medi-Cal members have the right to request a State Hearing from the California Department of Social Services after exhausting the appeal process. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

O~~ne~~C~~are~~ and O~~ne~~C~~are~~ C~~onnect~~ members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima is notified when a request is made by a member or member representative. CalOptima supports the process with providing the medical

records for the QIO's review. The QIO notifies the member or member representative and CalOptima of the outcome of their review. If the decision is overturned, CalOptima complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions ~~(PPCs)~~

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals.
2. Other provider-preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima's QI department for further research and reporting to government and/or regulatory agencies.

L~~ONG~~ONG-T~~ERM~~ERM S~~ERVICES~~ERVICES ~~AND~~AND S~~UPPORTS~~UPPORTS

L~~ong-T~~erm C~~are~~

The ~~Long-Term Care~~LTC case management program includes authorizations for the following facilities: ~~nurse case manager~~

- ~~Skilled nursing~~
- NF-A and NF-B~~Intermediate care~~, sub-acute care

~~- Intermediate care, developmentally disabled~~
~~- Intermediate care, developmentally disabled – habilitative~~
~~- Intermediate care, developmentally disabled – nursing~~

It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, ~~C~~congregate ~~L~~living ~~H~~health ~~F~~facilities and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days.~~.~~ There are two types of NFs: Onsite NFs where nurses make monthly or bi-monthly visits, and "FAX-IN" NFs (includes all out of county NFs) where NCMs do not visit but do review medical records sent to them via email or fax. ~~E~~either a~~A~~n on-site visit or FAX-IN process is scheduled to assess a ~~patient's~~member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes, as well as bedside evaluation of the member and support system (for onsite only). Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS or to a CBAS facility. Referrals to case management can also be made upon discharge when member needs indicate a referral is appropriate. ~~I~~In addition, the LTC staff provides

education to facilities and staff through monthly onsite visits, quarterly and annual workshops, or in response to individual facility requests, and when new programs are implemented.

CBAS

An outpatient, facility-based program offering day--time care and health and social services, to frail seniors and adults with disabilities to enable participants to remain living at home instead of in a nursing facility. Services may include: health care coordination; meal service (at least one per day at

center); medication management; mental health services; nursing services; personal care and social services; physical, occupational, and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center.

MSSP
CalOptima has responsibility for the payment of the MSSP in the County of Orange for individuals who have Medi-Cal. The program provides services and support to help persons 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to~~:~~, senior center programs; case management; money management and counseling; respite; housing assistance; assistive devices; legal services; transportation; nutrition services; home health care; meals; personal care assistance with hygiene; personal safety; and activities of daily living.

Transitions of Care ~~(TOC)~~

Transitions of Care (TOC) is a patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides OC and OCC members discharged from Fountain Valley Regional Hospital (or their caregivers) with tools and support to encourage and sustain self-management skills in an effort to minimize the potential of a readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:

- **Knowledge of Red Flags**: Member is knowledgeable about indications that their condition is worsening and how to respond.
- **Medication Self-Management**: Member is knowledgeable about medications and has a medication management system.
- **Patient-Centered Health Record (PHR)**: Member understands and uses a ~~Personal Health Record (~~PHR~~)~~ to facilitate communication with their health care team and ensure continuity of care across providers and settings.
- **Physician Follow-Up**: Member schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Case Management Process

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable. For further details of the structure, process, staffing, and overall program management please refer to the 2019 Case Management Program document.

Transplant Program

The CalOptima Transplant Program is coordinated by ~~CalOptima's~~ the Medical Director and Medi-Cal members are managed in collaboration with the Case Management department. Transplants for Medi-Cal only members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan. The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The ~~CalOptima~~ Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician, and facilities are assisted in order to assure timely, efficient, and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant staff, and the facilities. CalOptima monitors and maintains oversight of the Transplant Program~~,~~.

Coordination of Care~~.~~

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medi~~-caid~~Cal is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider in certain situations. CalOptima also coordinates continuity of care with other Medicaid health plans when a new member comes into CalOptima or a member terminates from CalOptima to a new health plan.

Over/Under Utilization

Over/under utilization monitoring is tracked by UM and reported to UMC. Measures are monitored and reviewed for over and underutilization, and/or changes in trends. Actions are determined based on trends identified and evaluated for effectiveness.

The following are measures tracked and monitored for over/under utilization trends:

- ER admissions
- Bed Days
- Admits per 1000
- ~~ALOS~~Average Length of Stay
- Readmission Rates
- Denial Rates
- Pharmacy Utilization Measures
- Overturn Rates — Provider per 1000 per Year
- Select HEDIS rates for selected measures
- Other areas as identified
-

P~~ROGRAM~~ROGRAM E~~VALUATION~~VALUATION

The UM Program is evaluated at least annually, and modifications made as necessary. The UM Medical Director and Director, UM evaluate the impact of the UM Program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- ~~Drug Utilization Review~~ (DUR~~)~~ profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIC and QAC for approval.

~~SATISFACTION~~ SATISFACTION ~~WITH THE~~WITH THE UM ~~PROCESS~~PROCESS

CalOptima provides an explanation of the GARS process, Fair Hearing, and Independent Review processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers, and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima QI department for investigation and resolution.

Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include, but are not limited to: member satisfaction survey results such as Consumer Assessment of Healthcare Providers and Systems (CAHPS)~~,~~; member/provider complaints and appeals that relate specifically to UM~~,~~; provider satisfaction surveys with specific questions about the UM process~~,~~; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, CalOptima develops an action plan and interventions to improve on

the areas of concern which may include staff retraining and member/provider education.

2020
UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Back to Agenda Back to Item

2020 UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

Himmet Dajee, M.D. **Date**
Utilization Management Medical Director

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Paul Yost, M.D. **Date**

Board of Directors Chair:

_____ _____

Paul Yost, M.D. **Date**

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members is in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all members.

Our Values — CalOptima CARES

Collaboration: We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability: We were created by the community, for the community, and are accountable to the community. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect: We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence: We base our decisions and actions on evidence, data analysis and industry- recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship: We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."
We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan
In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input.
- Be accountable for the decisions we make

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, ACA expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS.

A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services
Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.
- Dental services are provided through California's Denti-Cal program.

Members with Special Health Care Needs
To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including Orange County Health Care Agency (OC HCA) and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports
Since July 1, 2015, the Department of Health Care Services (DHCS) integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members into the scope of benefits provided by CalOptima. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare
Our OneCare (HMO SNP) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OneCare (OC) to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and

Medicare Parts A and B. To be a member of OC, a person must live in Orange County, and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services
In addition to the comprehensive scope of acute, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits, CalOptima OC members are eligible for enhanced services such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and an out of the country urgent/emergency care benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi- Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services
OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over-the-counter medication benefits and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community- based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services
PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participants. PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

PROGRAM INITIATIVES

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017–2019 Strategic Plan. In Orange County, the pilot is being led by the OC HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information sharing platform was launched in November 2018. For 2020, the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance.

As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitions to CalOptima in 2019**.** Under this program in Orange County, medical eligibility determination processes, the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with OC HCA.

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS. CalOptima planned to implement HHP in the following two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD), and July 1, 2020, for members with serious mental illness or Serious Emotional Disturbance (SMI).

CalOptima's goal is to target the highest-risk 3–5 percent of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible,

members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing related and accompaniment services to further support HHP members. Following implementation, CalOptima will consider opportunities for other entities to participate.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. To address this problem, Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health; health care; housing support services; community connections; and public social services. The county's WPC program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care — As part of the Whole Person Care program, services provide post-acute care for up to 90-days for homeless CalOptima members.
- Medical Respite Care — As an extension to the recuperative care program, CalOptima provides additional respite care beyond the 90 days of recuperative care under the Whole Person Care program.
- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), Orange County Health Care Agency's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members.
- Homeless Clinical 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 preventive care services at Orange County homeless shelters.

Hospital Discharge Process for Members Experiencing Homelessness — Support is provided to assist hospitals with the increased cost associated with discharge planning under new state requirements.

Population Health Management (PHM)

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care

coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping Members Healthy
2. Managing Members with Emerging Risks
3. Patient Safety or Outcomes Across Settings
4. Managing Multiple Chronic Conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima has developed a comprehensive PHM Strategy, which includes actions to address the needs of our culturally diverse members across the continuum of care based on the National Quality Assurance Committee (NCQA) Population Health Management standards. CalOptima's PHM Strategy aims to ensure that care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

CalOptima's PHM Strategy is based on numerous efforts to assess the health and well-being of our members, such as the Member Health Needs Assessment. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101.

The PHM strategy addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual, and environmental stressors, to improve health outcomes.

With Whom We Work

Contracted Health Networks/Contracted Network Providers
Providers have several options for participating in CalOptima's programs providing health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct-Administration and/or CalOptima Community Network (CCN) and/or contract with a CalOptima health network (HN). CalOptima members can choose CCN or one of 13 HNs, representing more than 8,500 practitioners.

CalOptima Direct (COD)
CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)
CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including dual-eligible (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. Members enrolled in CalOptima Direct-Administrative are not HN eligible.

CalOptima Community Network (CCN)
The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered internally by CalOptima and available for members to select, supplementing the HN delivery model and creating additional capacity for growth.

CalOptima Contracted Health Networks

CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

Health Network/Delegate	Medi Cal	One Car	OneCa re
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC	SRG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	HMO	SRG	HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Medical Group	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management (UM)
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2020

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

Membership Data as of November 30, 2019

Total CalOptima Membership
755,539

Program	Members
Medi-Cal*	739,601
OneCare Connect	14,065
OneCare (HMO SNP)	1,498
Program of All-Inclusive Care for the Elderly (PACE)	375

Note: The Fiscal Year 2019-20 Membership Data began on July 1, 2019.
*Includes prior year adjustment

Member Age (All Programs)

11%	0 to 5
29%	6 to 18
29%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
27%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

UTILIZATION MANAGEMENT PROGRAM

UM Purpose

The purpose of the Utilization Management (UM) Program Description is to define CalOptima's structure and processes for review of health care services, treatment and supplies, including assignment of responsibility to appropriate individuals, to deliver quality, coordinated health care services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, cost effective and timely manner by delegated and non-delegated providers.

UM Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive, emergency, primary, specialty, behavioral health, home and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima members.

- Assist in the coordination of medically necessary medical and behavioral health care services in accordance with state and federal laws, regulations, contract requirements, NCQA Standards and evidence-based clinical criteria.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address concerns about access, availability, and timeliness of care.
- Clearly define staff responsibility for activities regarding decisions based on medical necessity.
- Establish and maintain processes used to review medical and behavioral health care service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on Medical Necessity and/or benefit coverage.
- Identify and refer high-risk members to Case Management Programs, including Complex Case Management, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- Promote a high level of member, practitioner and stakeholder satisfaction.
- Protect the confidentiality of member protected health information and other personal information.
- Identify potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- Identify issues that contribute to over or underutilization or the inefficient or inappropriate use of health care services.
- Promote improved member health and well-being by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- Educate practitioners and other providers, including delegated HNs, on CalOptima's UM Program, policies and procedures.
- Monitor utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.

UM Program Structure

The UM Program is designed to work collaboratively with delegated entities, including, but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community in an effort to assure that the member receives appropriate, cost efficient, quality- based health care.

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA) and NCQA at least annually. The UM Program is revised and improved, as appropriate. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network.

Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization.

The organization chart and the UM Program's committees reporting structure reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

The UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer; Deputy Chief Medical Officer; Medical Director(s) of UM; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima delegates UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM Program Description and CalOptima policies and procedures. Delegation is dependent upon the following factors:

- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards as documented in the UM policies and procedures, including timeframes outlined in CalOptima's policies and procedures.

CalOptima retains accountability for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:

- Frequent reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight department, Utilization Management Committee (UMC) and/or Quality Improvement Committee (QIC).
- Regular audits of delegated HNs UM activities by the Audit and Oversight department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA and CalOptima standards and program requirements.
- Annual approval of the delegate's UM program (or portions of the program that are delegated); as

well as any significant program changes that occur during the contract year.

In the event the delegated provider does not adequately perform contractually specified delegated duties, CalOptima takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation adjustments, or de-delegation.

Long-Term Services and Supports
CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima is responsible for clinical review and medical necessity determination for the following levels of care:
    - Nursing Facility Level B (NF-B)
    - Nursing Facility Level A (NF-A)
    - Subacute Adult and Pediatric
- Medical necessity for LTC is evaluated based upon the DHCS Medi-Cal Criteria Chapter, Criteria for Long-Term Care Services, and Title 22, CCR, Sections 51118, 51120, 51121, 51124, 51212, 51215, 51334, 51335, 51343, 51343.1 and 51343.2.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization. CalOptima evaluates medical necessity for services using the CBAS Eligibility Determination Tool (CEDT).
- MSSP: Home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for long-term nursing facility care. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization. The CalOptima MSSP site adheres to the California Department of Aging contract and eligibility determination criteria.

Behavioral Health Services

Medi-Cal
CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Behavioral Health (BH) services include but are not limited to: individual and group psychotherapy, psychology, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger that meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific timeframe. CalOptima provides direct oversight, review, and authorization of BHT services.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) (formerly Screening, Brief Intervention, and Referral to Treatment [SBIRT]) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at **855-877-3885**. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits including UM, claims, credentialing the provider network, member services and QI.

OC and OCC
CalOptima previously contracted with Magellan Health Inc., to directly manage the BH benefits for OC and OCC members. Effective 1/1/2020, OC and OCC covered BH services were fully integrated within CalOptima internal operations. OC and OCC members can access BH services by calling the CalOptima Behavioral Health Line. Members will be connected to CalOptima representative for BH assistance.

CalOptima offers AMSC services in the PCP setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

Linkages with Community Resources
In addition, CalOptima provides linkages with community programs to members with special health care needs, or high risk or complex medical and developmental conditions. These linkages are established through special programs, such as the CalOptima Community Liaisons, PCCs, BH Integration (BHI), LTSS and specific program contracts and MOUs with other community agencies and programs, such as the OC HCA's CCS, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate state agencies and specialist care when the benefit coverage of the member dictates. The UM department coordinates activities with the Case Management department to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

Board of Directors
The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and service provided to CalOptima members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) — which oversees the functions of the QI Committee described in CalOptima's State and Federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as discussed below.

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to CMO. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIC and the QAC on an annual basis.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the QAC to review and make recommendations to the Board regarding accepting the overall QI Program and annual evaluation, and routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and improvements achieved. The QAC also makes recommendations for annual modifications of the QI Program and actions to achieve the Institute for Healthcare Improvement's Quadruple Aim expanding on the CMS' Triple Aim:

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee
The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventative services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers
- Family support
- Foster children
- LTSS

- Medi-Cal beneficiaries
- Medically indigent persons
- OC HCA
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by OC HCA and OC SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee
The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - OC SSA
    - OC Community Resources Agency, Office on Aging
    - OC HCA, Behavioral Health
    - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee
The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent a broad provider community that serves CalOptima members. The PAC is comprised of 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of OC HCA, which maintains a standing seat. PAC meets at least quarterly and are open to the public. The 15 seats include:

- HN
- Hospitals
- Physicians (3 seats)
- Nurse

- Allied health services
- Community health centers
- OC HCA (1 standing seat)
- LTSS (LTC facilities and CBAS) (2 seats)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee
In 2018, CalOptima's Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC), as required by the state as part of California Children's Services (CCS) becoming a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning WCM, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima WCM. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: 7–9 seats
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
    - CalOptima members age 18–21 who are a current recipient of CCS services; or
    - Current CalOptima members over the age of 21 who transitioned from CCS services
- Interests of children representatives: 2 to 4 seats
    - Community-based organizations; or
    - Consumer advocates

Members of the Committee shall serve staggered two-year terms. Of the above seats, five members serve an initial one-year term (after which representatives for those seats will be appointed to a full two-year term), and six will serve an initial two-year term. WCM FAC meets at least quarterly and meetings are open to the public.

Role of CalOptima Officers for UM Program

CalOptima's CMO, Chairperson of the UMC, Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the State and Federal Contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO), along with the Deputy Chief Medical Officer (DCMO) oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO oversees the strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Services and Supports (LTSS) and Enterprise Analytics (EA).

Executive Director, Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Case Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO, DCMO and the ED of Quality and Population Health Management (Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima's strategic plan, goals and objectives. The ED of CO is expected to anticipate, continuously improve, communicate and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources.

Medical Director, Utilization Management is appointed by the CMO and/or DCMO, and is responsible for the direction of the UM Program objectives, as well as evaluation of the UM Program. The medical director ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. The medical director ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and utilizes evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the medical director also provides supervisory oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. Provides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The medical director of UM ensures physician availability to staff during normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the bi-weekly UM Workgroup meetings and participates in the CalOptima Medical Directors Forum and QIC.

Medical Director, Behavioral Health is the designated behavioral healthcare practitioner in the QI and UM programs, and serves as a participating member of the UMC, QIC and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima members. Clinical oversight is also provided for BH benefits and services provided to members. The medical director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes. Additionally, the medical director is involved in the implementation, monitoring, evaluating and directing of the behavioral health aspects of the UM Program.

Medical Director, Senior Programs is a key member of the medical management team and is responsible for the Medi-Medi programs (OC and OCC), MLTSS programs, Case Management and Transitions of Care programs. The medical director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The medical director works in collaboration with the other medical directors and the clinical staff within PHM, GARS, and Provider Relations. The medical director works closely with the nursing and non-clinical leadership of these departments.

Medical Director, Population Health Management, Health Education, Program for All Inclusive Care for the Elderly (PACE) is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of PHM, disease management and health education programs, while also providing clinical quality oversight of the PACE Center.

Director, Utilization Management
Director is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in Utilization Management (UM) departmental operations. This position will provide leadership and direction to the Utilization Management department to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. The incumbent will have oversight of CalOptima's Utilization Management program for CalOptima Community Network, CalOptima Direct and the delegated health networks. The Director is expected to serve as a liaison for various internal and external committees, workgroups, and operational meetings.

Director, Behavioral Health Services provides operational oversight for BH benefits and services provided to members. The director is responsible for monitoring, analyzing, and reporting to senior staff on changes in the health care delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and BH care services. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executive staff, members, providers, HN management, legal counsel, state and federal officials, and representatives of other agencies.

Director, Quality Improvement is responsible for assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED of Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

Director, Quality Analytics provides data analytical direction to support quality measurement activities for the agency-wide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory, and accreditation agencies.

Director, Population Health Management provides direction for program development and implementation for agency-wide population health initiatives. Ensures linkages supporting a whole-person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. Provides direct care coordination and health education for members participating in non-delegated health programs such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

Director(s), Audit and Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima policies, and industry best practices. The directors ensure that CalOptima and its subcontracted HNs perform consistently with both CMS and state requirements for all programs. Specifically, the directors lead the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the directors are responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. These positions interact with the Board of Directors, CalOptima executives, departmental management, HN management and Legal Counsel.

RESOURCES

UM Resources

The following staff positions provide support for the UM department's organizational/operational functions and activities:

Manager, Utilization Management (Concurrent Review [CCR]) manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements, and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in UM activities.

Supervisor, Utilization Management (CCR) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The supervisor is a resource to the CCR staff regarding CalOptima policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years of managed care experience preferred
- Supervisor experience in Managed Care/UM preferred.

Manager, Utilization Management (Prior Authorization [PA]), manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima policies and procedures, and

regulatory and accreditation agency requirements. The manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Experience & Education

- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in Utilization Management activities.

Supervisor, Utilization Management (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff — regarding CalOptima policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing — while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted RN license or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years of managed care experience.
- Supervisor and/or Lead experience in Managed Care/UM preferred.

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria. These positions audit clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, ensures denial reason is written in plain language that a lay person understands, is specific to the clinical information presented and criteria referenced and is prepared using the appropriate threshold language template. They work with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

Experience & Education

- Current and unrestricted California Board LVN or CA RN license.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years managed care experience
- Excellent analytical and communication skills required

Medical Case Managers (RN/LVN) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality, and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria. This activity is conducted prospectively, concurrently, or retrospectively. They also provide concurrent oversight of referral/prior authorization and inpatient case

management functions performed at the HMOs, PHCs, and SRGs; and act as liaisons to Orange County based community agencies in the delivery of health care services. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- Current and unrestricted California Board LVN or RN license.
- Minimum of 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Medical Authorization Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They also authorize requested services according to departmental guidelines. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- High school graduate or equivalent; a minimum of 2 years of college preferred.
- 2 years of related experience that would provide the knowledge and abilities listed.

Program Specialist provides high-level administrative support to the Director, UM, the UM Managers, Supervisors and the UM Medical Directors.

Experience & Education

- High school diploma or equivalent; a minimum of 2 years of college preferred.
- 2–3 years previous administrative experience preferred. Courses in basic administrative education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.

Pharmacy Department Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements, and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery, including, but not limited to, the contract with the third-party auditor, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Doctor of Pharmacy (Pharm.D) required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have

developed the knowledge and abilities listed.

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima Delegated Health Plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, researches, develops, and updates drug UM strategies and intervention techniques. The Pharmacy manager develops and implements methods to measure the results of these programs, assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T), Committee , interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- At least 3 years' experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima HNs and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs. They assist the Pharmacy director in preparing drug monographs and reports for the P&T, interact frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- 3 years of experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are

trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

Experience & Education

- Pharm.D degree from an accredited college of pharmacy.
- Eligibility for licensure in California.

Pharmacy Benefits Manager (PBM) staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's P&T. CalOptima pharmacists with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria, and perform all denials.

LTSS Resources

The following staff positions provide support for LTSS operations:

Director, Long-Term Support Services develops, manages and implements LTSS, including Long-Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs. The director is responsible for ensuring high quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. The director also develops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF) and other LTSS services.

Experience & Education

- Bachelor's degree in Nursing or in a related field required.
- Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable.
- 5–7 years varied related experience, including 5 years of supervisory experience with experience in supervising groups of staff in a similar environment.
- Some experience in government or public environment preferred.
- Experience in the development and implementation of new programs.

Manager, Long-Term Support Services (CBAS/LTC) is expected to develop and manage the LTSS department's work activities and personnel. The manager ensures that service standards are met, and operations are consistent with CalOptima's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for CalOptima's members who are eligible for and/or receiving LTSS. This position must have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, HNs, and other internal and external customers in a professional and competent manner. The manager works in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTSS services.

Experience & Education

- A current and unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5–7 years varied clinical experience required.
- 3–5 years supervisory/management experience in a managed care setting and/or nursing facility.

- Experience in government or public environment preferred.
- Experience in health with geriatrics and persons with disabilities.

Supervisor, Long-Term Support Services (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting. This position is responsible for the management of the day-to-day operational activities for LTSS programs: LTC, CBAS, and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor resolves member and provider issues and barriers, ensuring excellent customer service. Additional responsibilities include managing staff coverage in all areas of LTSS to complete assignments, and orientation and training of new employees to ensure contractual and regulatory requirements are met.

Experience &Education

- A current unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years varied experience at a health plan, medical group, or skilled nursing facilities required.
- Experience in interacting/managing with geriatrics and persons with disabilities.
- Supervisory/management experience in UM activities.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.

Medical Case Managers, Long-Term Support Services (MCM LTSS), are part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for CalOptima members in LTC facilities and members receiving CBAS. They review and determine medical eligibility based on approved criteria/guidelines, NCQA standards, and Medicare and Medi-Cal guidelines, and facilitate communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality and cost-effective outcomes. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. These positions are the subject matter experts and acts as liaisons to Orange County based community agencies, CBAS centers, skilled nursing facilities, members and providers.

Experience & Education

- A current and unrestricted RN license or LVN license in the State of California.
- Minimum of 3 years managed care or nursing facility experience.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time.

Program Manager, LTSS is responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. This position is responsible for the annual CBAS Provider Workshop, CBAS process improvement, reporting requirements, reviewing the monthly files audit,

developing inter-rater reliability questions, performing psychosocial and functional assessments, and serving as a liaison and key contact person for DHCS, California Department Office of Aging (CDA), CBAS Coalition and CBAS centers. The manager is responsible for developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.

Experience & Education

- Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required. Masters preferred.
- Minimum of 3 years CBAS and program development experience.
- Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.
- Previous work experience in managing programs and building relationships with community partners is preferred.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office (approximately 5% of the time or more will involve traveling to CBAS centers and community events).

Behavioral Health Integration Resources

The following staff positions provide UM support for Behavioral Health Integration (BHI) operations:

Manager, Behavioral Health (Care Management) is responsible for overseeing the development, implementation, and daily operations of the Care Management teams including Transitional Care Management and BHT services. The position ensures the delivery of quality and consistent concurrent review, recommendations, and referrals in accordance with CalOptima policies and procedures as well as collaborates with other internal CalOptima departments to ensure all regulatory requirements are met.

Experience & Education

- Master's degree in Behavioral Health or other related degree is required.
- A current and unrestricted Licensed Clinical Social Worker (LCSW) or Licensed Marriage and Family Therapist (LMFT) license in the State of California required, Licensed Psychologist is preferred.
- 4 years of supervisor or manager level experience required.
- 1 year experience in behavioral health audits (including CMS, DHCS, DMHC and NCQA).
- 1-year experience in developing policies and procedures to meet federal and state regulatory requirements.
- 1-year experience in developing sound and responsible business plans and financial models preferred.

Program Manager, Sr. (BH) is responsible for regulatory requirements governing authorization processing, monitoring utilization patterns, and developing BH UM goals and activities. The position works under the direction of the Director, Behavioral Health Services (Integration), Medical Director of Behavioral Health and/or other department leadership to support the department's UM activities.

Experience & Education

- Bachelor's degree in a behavioral health related field required; Master's degree in Health Administration, Social Work, Marriage and Family Therapy, Public Health, or other related degree preferred.
- 4 years of experience working in a managed care environment, with specific experience in BH UM.
- 4 years of supervisor or manager level experience required.
- Experience in a government or public environment strongly preferred.
- 2 years of experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program required.
- 2 years of experience and aptitude for working in a highly matrixed, mission-driven organization required.

Supervisor, Behavioral Health, (BHT) is responsible for the daily operation of the BHT services program. The position oversees Applied Behavior Analysis (ABA) Member Liaison Specialists ensuring members receive appropriate provider linkage. The Supervisor will also oversee and assist Care Managers with reviewing assessments and treatment plans submitted by providers for adherence to BHT "best practice" guidelines. The Supervisor is accountable for establishing and achieving quality and productivity standards for the teams and for ensuring compliance with department policies and procedures.

Experience & Education

- Master's degree in Behavioral Health or other related degree is required.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- 3 or more years of supervisor level experience in clinical management of ABA services is required.
- 3 or more years of experience providing ABA therapy to children diagnosed with autism spectrum disorder (ASD) is required.

Medical Case Managers (BH) are responsible for clinical review and recommendations related to Interdisciplinary Care Team (ICT) meetings, inpatient and outpatient psychiatric authorization requests from BH providers and completing inpatient CCR and transitional care for OC and OCC members. They are responsible for adhering to CalOptima's prior authorization approval process which includes reviewing authorization requests for medical necessity, consulting with the manager and Medical Director as needed. They also review prior authorization requests for outpatient mental health services.

Experience & Education

- Current and unrestricted RN license to practice in the State of California
- Minimum of 3 years current BH clinical experience or an equivalent combination of education and experience required.
- Active Certified Case Manager (CCM) certification preferred.
- Experience in a prior authorization and/or managed care environment preferred.
- Experience with inpatient concurrent review strongly preferred.

Medical Case Manager (BH) is responsible for reviewing and processing requests for authorization and notification of psychological testing and psychiatric inpatient services from health professionals, clinical facilities and ancillary providers. The position is responsible for prior authorization and referral related processes related to transitional care. Utilizes medical criteria, policies, and procedures to authorize referral requests from BH professionals, clinical facilities and ancillary providers

Experience & Education

- High school diploma required, Associates or Bachelor's degree in related field preferred
- Current and unrestricted LVN license to practice in the State of California required
- 3 years of clinical experience required
- Inpatient behavioral health experience preferred
- Active CCM certification preferred

Care Manager is responsible for the oversight and review of BHT services offered to members that meet medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from BH providers. This position is also responsible for UM and monitoring activities of autism services provided in community-based setting. The manager directly interacts with provider callers, acting as a resource for their needs.

Experience & Education
- Master's degree in Behavioral Health or another related field is required.
- Board Certified Behavioral Analyst (BCBA) or Board-Certified Behavioral Analyst-Doctoral (BCBA-D) is required.
- 4 or more years providing ABA therapy to children diagnosed with ASD is required.
- Experience in clinical, medical utilization review, and/or quality assurance is preferred.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Member Liaison Specialist (Autism) is responsible for providing care management support to members that meet medical necessity criteria seeking BHT services, including ABA. This position assists members in linking BHT services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the BH system of care. This position will act as a consultative liaison to assist members, HNs and community agencies to coordinate BHT services.

Experience & Education
- High school diploma or equivalent is required.
- Bachelor's degree in behavioral health or related field is preferred.
- 2 years of experience in behavioral health, community services, or other social services setting required.
- Experience in working with children diagnosed with ASD.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.
- Driver's license and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Qualifications and Training
CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:
- CalOptima New Employee Orientation.
- HIPAA and Privacy/Corporate Compliance.

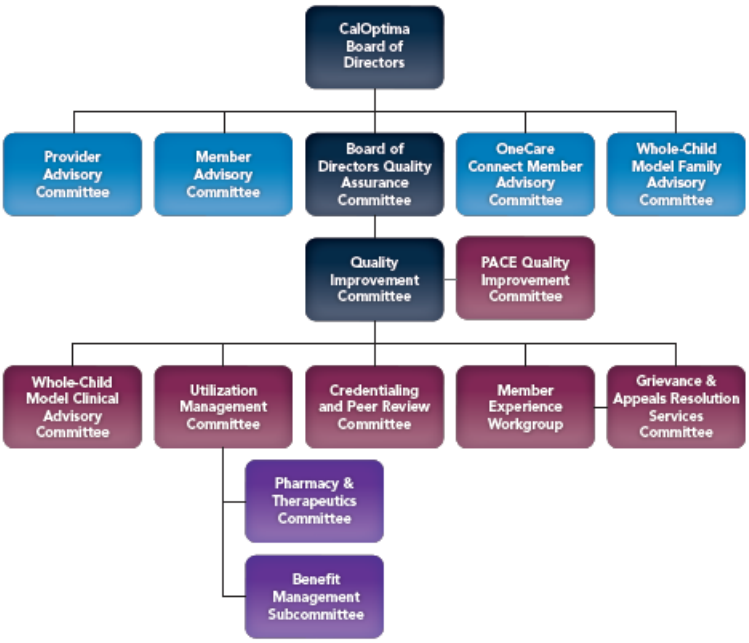
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.).
- UM Program, policies/procedures, etc.
- MIS data entry.
- Application of Review Criteria/Guidelines.
- Appeals Process.
- Seniors and Persons with Disabilities Awareness Training.
- OC and OCC Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations using inter-rater reliability training and annual competency testing. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health professionals provide day-to-day supervision of assigned UM staff, as well as oversight of the UM process and all medical necessity decisions. The supervisor also participates in UM staff training to ensure understanding of UM concepts and practices and monitor for consistent application of criteria, for each level and type of UM decision. The supervisors perform monthly quality audits for each teammate who reports to them to monitor and ensure adequacy of documentation and consistent application of criteria. UM supervisors are available to UM staff either on site or telephone during normal business hours. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and BH benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure from the State of California. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients, is prohibited. All medical management staff is required to sign an Affirmative Statement regarding this prohibition annually.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

2020 Committee Organization Structure — Diagram



UMC

The UM Committee (UMC) promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.
The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, and SRGs, to identify areas of under or over utilization that may adversely impact member care and is responsible for the annual review and approval of medical necessity criteria and protocols, the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. With the assistance of the UM specialist, the director of UM maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIC. Oversight and operating authority of UM activities is delegated to the UMC which reports up to QIC and ultimately to QAC and the Board of Directors.

UMC Scope and Responsibilities

- Provides oversight and overall direction for the continuous improvement of the UM program, consistent with CalOptima's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima and its delegated HN.

- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
- Reviews and approves the UM Program Description, Medical Necessity Criteria, UMC Charter and UM Program Evaluation on an annual basis.
- Reviews and analyzes UM Operational and Outcome data; reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
- Reviews and approves annual UM Metric targets and goals.
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promotes a high level of satisfaction with the UM program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, assesses, and recommends utilization management best practices used for selected diagnoses or disease classes.
- Conducts under/over utilization monitoring in accordance with UM Policy and Procedure GG.1532 Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:

  Direct Subcommittee Reports:
    - Benefit Management Subcommittee (BMSC)
    - P&T

  Departments Reporting Relevant Information on UM Issues:
    - Delegation Oversight
    - Behavioral Health
    - Grievance and Appeals
    - UM Workgroup
    - LTSS
- Reports to the QIC on a quarterly basis; communicates significant findings and makes recommendations related to UM issues.

UMC Membership

Voting Members:

- CMO
- Medical Director UM
- Medical Director Behavioral Health
- Medical Director Senior Programs
- Medical Director Quality and Analytics
- Executive Director, Clinical Operations
- Up to six participating practitioners from the community*

* Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists, and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

The UMC is supported by:

- Director, UM
- Medical Director, Whole Child Model

- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

Benefit Management Subcommittee (BMSC)
The BMSC is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division (MMCD), All Plan Letters (APLs), and the Medi-Cal Manual.

BMSC Scope
The BMSC is responsible for the following:
- Maintaining a consistent benefit set for all lines of business.
- Revising and updating CalOptima's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility of the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Membership
- Medical Director, Utilization Management — Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Claims Management
- Director, Claims
- Director, Coding Initiatives

The BMSC meets at least six times per year, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

Integration with the QI Program
The UM Program is evaluated and submitted for review and approval annually by UMC, QIC and QAC, with final review and approval by the Board of Directors.
- The UM program is evaluated, revised and prepared for approval by the UM Director in conjunction with the Executive Director of Clinical Services, Chief Medical Officer, Deputy Chief Medical Director and Utilization Management Medical Director prior to submission for committee review and approval.
- Utilization data is collected, aggregated and analyzed including, but not limited to, denials, unused authorizations, provider preventable conditions, and trends representing potential over or under utilization.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization review activities. These issues are referred to the QI staff for evaluation.
- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.
- The QIC reports to the Board QAC.

Integration with Other Processes

The UM Program, Case Management Program, BH Program, Managed LTSS Programs, P&T, QI, Credentialing, Compliance, and Audit and Oversight are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to the QI department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. CalOptima requires that all individuals who serve on UMC or who otherwise make decisions on UM, quality oversight and activities, timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.

This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members

of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QIC and the subcommittees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The HMOs, PHCs, and SRGs hold all information in the strictest confidence. Members of the QIC and the subcommittees sign a Confidentiality Agreement. This agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the State Contract.

UM Process

The UM process encompasses the following program components: referral/prior authorization, concurrent review, post-stabilization services, ambulatory review, retrospective review, discharge planning and care coordination and second opinions. All approved services must meet medical necessity criteria. The clinical decision process begins when a request for authorization of service is received. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified.

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the DHCS and CMS. A variety of program documents, regulations, policy letters and all CMS benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the Audit and Oversight department via its delegation oversight team for compliance.

Review and Authorization of Services

Medical Necessity Review

Medical necessity review requires consideration of the members' circumstances, relative to appropriate clinical criteria and CalOptima policies, applying current evidence-based guidelines, and consideration of available services within the local delivery system. These decisions are consistent with current evidence-based clinical practice guidelines.

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with CMS and the State of California for Medi-Cal, OC and OCC. Medically necessary means:

- For Medi-Cal, covered services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Medi-Cal members receiving MLTSS, medical necessity is determined in accordance with member's current needs assessment and consistent with person-centered planning. When determining the medical necessity for Medi-Cal member 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 sections 14132(v).

- For Medicare, covered services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C section 1395y.

The CalOptima UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost-efficient manner, without compromising quality. Physicians, or pharmacists or psychologists in appropriate situations, review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified physician or pharmacist.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Admission Review
- Post-stabilization inpatient review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for health network members

The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications or termination of services.
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological situation
    - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or

guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action per CalOptima Policy and Procedure GG.1508, Authorization and Processing of Referrals.

- Reasons for decisions are clearly documented in the medical management system, including criteria used to make the determination.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time frames, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services.
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.
- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- All members are notified in writing of any decision to deny, modify, or delay a service authorization request.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director (Peer-to-Peer) or a copy of the specific criteria utilized.

The information that may be used to make medical necessity determinations includes, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director, Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima

program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Prior Authorization

Prior authorization requires the provider or practitioner to submit a formal medical necessity determination request and all relevant clinical information related to the request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the CalOptima website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Link system allows for non-urgent on-line authorizations to be submitted by providers and processed electronically. Some referrals are auto adjudicated through referral intelligence rules (RIR). Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone based on the urgency of the request.

Referrals

A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. PCPs are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians, as noted on the Prior Authorization Required List, and all non-emergency out-of- network practitioners

Second Opinions

A second opinion may be requested when there is a question concerning diagnosis or options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of- network practitioner, if there is no in-network practitioner available.

Extended Specialist Services

Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "Standing Referral" policy and procedure, Standing Referral: GG.1112, includes guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers

If a member or provider requires or requests a provider out-of-network for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a

number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise, and complexity of the case.

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice, and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima distributes an affirmative statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

PHARMACEUTICAL MANAGEMENT

Pharmacy Management is overseen by the CMO, and CalOptima's Director, Pharmacy. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima website.

The P&T is responsible for development of the CalOptima Approved Drug List (Formulary), which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the CalOptima Approved Drug List are communicated to both members and providers. If the following situations exist, CalOptima evaluates the appropriateness of prior authorization of non-formulary drugs:

- No formulary alternative is appropriate, and the drug is medically necessary.
- The member has failed treatment or experienced adverse effects on the formulary drug.
- The member's treatment has been stable on a non-formulary drug and change to a formulary drug is medically inappropriate.

To request prior authorization for outpatient medications not on the CalOptima Formulary, the physician or physician's agent must provide documentation to support the request for coverage. Documentation is provided via the CalOptima Pharmacy Prior Authorization (PA) form, which is faxed to CalOptima's PBM for review. All potential authorization denials are reviewed by a pharmacist at CalOptima, as per DHCS requirements. The Pharmacy Management department profiles drug utilization by members to identify instances of polypharmacy that may pose a health risk to the member. Medication profiles for

members receiving multiple medication fills per month are reviewed by a clinical pharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over-utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

Pharmacy Determinations

Medi-Cal
CalOptima's Pharmacy Management department delegates initial prior authorization review to the PBM based on clinical prior authorization criteria developed by the CalOptima Pharmacy Management staff and approved by the P&T. The PBM may approve or defer for additional information, but final denial and appeal determinations may only be made by a CalOptima pharmacist or Medical Director. In addition, final decisions for requests that are outside of the available criteria must be made by a CalOptima pharmacist or Medical Director. CalOptima's written notification of pharmacy denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss pharmacy UM denial decisions.

OC/OCC
CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Formulary
The CalOptima drug Formularies were created to offer a core list of preferred medications to all practitioners. Local providers may make requests to review specific drugs for addition to the Formulary. The Formulary is developed and maintained by the P&T. Final approval from the P&T must be received to add drugs to the Formulary. The CalOptima Formularies are available on the CalOptima website or in hard copy upon request.

Pharmacy Benefit Manager
The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, pharmacy help desk, prior authorization, clinical services and quality improvement functions. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity the PBM is monitored according to the Audit and Oversight department's policies and procedures.

Behavioral Health Determinations

Medi-Cal
CalOptima's BHI department performs prior authorization review for BHT services and psychological

testing. Prior authorization requests are reviewed by BH UM staff that consist of Medical Case Managers and Care Managers (BCBA).

Determinations are based on criteria from MCG Guidelines, APL, and CalOptima policy (approved by DHCS).

OC/OCC
CalOptima has previously delegated Magellan Health Inc. to directly manage the behavioral health utilization management functions for OneCare/OneCare Connect. Effective January 1, 2020, CalOptima's BHI department will perform prior authorization review functions for OC/OCC covered behavioral health services. Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program, and psychological testing. Prior authorization requests are reviewed by BH Medical Case Managers. Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL), and CalOptima policies.

The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may only be made by a Licensed CalOptima Psychologist or Medical Director. CalOptima's written notification of BH modifications and denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
  A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss BH UM denial decisions.

UM Criteria

CalOptima conducts Utilization Review using UM criteria that are nationally recognized, evidence-based standards of care and include input from recognized experts in the development, adoption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Such criteria and guidelines include, but are not limited to:

Medi-Cal

1. Federal and state law mandates (i.e. CMS, DHCS)
2. Medi-Cal Manual of Criteria and Medi-Cal Benefits Guidelines
3. EPSDT
4. Nationally recognized evidence-based criteria such as Milliman Care Guidelines (MCG), U.S. Preventative Services Task Force Recommendations and National Comprehensive Cancer Guidelines, etc.
5. Transplant Centers of Excellence guidelines
6. Preventive health and/or society guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology [ACOG] Guidelines, American Medical Association (AMA) and National Guidelines Clearinghouse)
7. CalOptima Policy & Procedures and/or Clinical Benefits & Guidelines

Whole Child Model

In addition to the Medi-Cal hierarchy above:

1. CCS Numbered Letters (N.L.s) and county CCS Program Information Notices for decisions related to CCS and Whole Child Model.

Medicare

For OC and OCC:

1. Federal and state law mandates (i.e. CMD, DHCS)
2. CMS Guidelines Local and National Coverage Determinations (LCD, NCD)
3. Medicare Part D: CMS-approved Compendia (for medications)
4. Medi-Cal Manual of Criteria and Medi-Cal Benefits Guidelines
5. Nationally recognized evidence-based criteria such as MCG, UpToDate, U.S. Preventative Services Task Force Recommendations, and National Comprehensive Cancer Guidelines, etc.
6. Transplant Centers of Excellence guidelines
7. Preventive health and/or society guidelines (e.g., U.S. Preventive Services Task Force, ACOG Guidelines, AMA, National Guidelines Clearinghouse)
8. CalOptima Policy & Procedures and/or Clinical Benefits & Guidelines

Delegated HNs must utilize the same or similar nationally recognized criteria.

Due to the dynamic state of medical/health care practices, each medical decision must be case- specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Authorization Types

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	UM Nurse Reviewer**	Medical Director/ Physician Reviewer (Denials and Modifications)
Chemotherapy – all request types reviewed by Pharmacy department	MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines			X
DME (Custom & Standard)	MCG / Medi-Cal and Medicare Manuals		X	X
Diagnostics	MCG / Medi-Cal and Medicare Manuals		X	X
Hearing Aids	Medi-Cal and Medicare Manuals	X	X	X
Home Health	MCG / Medi-Cal and Medicare Manuals		X	X
Imaging	MCG / Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals	X	X	X
Injectables	MCG / Medi-Cal and Medicare Manuals		X	X
Inpatient hospital services	MCG / Medi-Cal and Medicare Manuals		X	X
Medical Supplies (DME Related)	MCG / Medi-Cal and Medicare Manuals	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	MCG / Medi-Cal and Medicare Manuals		X	X
Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG / Medi-Cal and Medicare Manuals		X	X
Prosthetics	MCG / Medi-Cal and Medicare Manuals		X	X
Radiation Oncology	MCG / Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	MCG / Medi-Cal and Medicare Manuals		X	
Transplants	DHCS Guidelines/ MCG		X	X

* If Medical Necessity criteria is not met, the request is referred to a UM Nurse Reviewer for further review and determination.

** If Medical Necessity criteria is not met, the request is referred to a Medical Director/Physician Reviewer for further review and determination.

Long-Term Support Services

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer (Denials and Modifications)
Community-Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		X	X
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51335		X	X
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51334		X	X
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Sections 51003 and 51303		X	X
Long-Term Care: Intermediate Care Facility / Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Sections 51343 and 51164	X DDS or DMH Certified	X	X
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	X	X	X

* If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

Behavioral Health Services

Authorization Type*	Criteria Utilized	Medical Case Manager	Care Manager (BCBA)	Medical Physician Reviewer / Licensed Psychologist
Psychological Testing	Title 22, MCG, Medi-Cal and Medicare Manuals, CalOptima policy	X		X
Behavioral Health Treatment (BHT) services (Medi-Cal only)	Title 22, WIC Section 14132, MCG, H&S Code 1374.73, Medi-Cal Manual, CalOptima policy DHCS APL 18-006	X	X	X

* If Medical Necessity is not met, the request is referred to the Medical Physician Reviewer/Licensed Psychologist for review and determination.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may

consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

New Technology Review
The P&T and BMSC shall study the medical, social, ethical, and economic implications of new technologies in order to evaluate the safety and efficacy of use for members, in accordance with CalOptima Policy GG.1534 Evaluation of New Technology and Uses.

Practitioner and Member Access to Criteria
At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM department or may discuss the UM decision with CalOptima Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-service to review all required provider trainings, including operational and clinical information such as, UM timeliness of decisions. In addition, Provider Relations also provides any related policies with regard to UM timeliness of decisions. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability
At least annually, the CMO and Executive Director, Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director, Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, UM leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight. The IRR is reported to the UMC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from the committee.

Provider and Member Communication
Members and practitioners can access UM staff through a toll-free telephone number **888-587-8088** at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at **800-735-2929**. The phone numbers for these are included in the Member Handbook, on the CalOptima website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services.

Inbound and outbound communications may include directly speaking with practitioners and members, faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima or notifies CalOptima on-call nurse in cases requiring immediate response. A log is forwarded to the UM department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer
The CalOptima Medical Director or appropriate practitioner reviewer (BH and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling the direct dial number for the Medical Director at the bottom of the provider denial notification. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner. Whenever a peer-to-peer request is made, documentation is added to the denied referral within Guiding Care, our UM system.

UM Staff Access to Clinical Expertise
The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, with the support of the UMC, have the authority, accountability and responsibility for denial determinations. For those contracted delegated HNs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records
During prospective and concurrent telephonic review, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information
CalOptima's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g. discharge planning, case management, disease management, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider Communication to Member
CalOptima's UM program in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or absence of treatment.
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

TIMELINESS OF UM DECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to

minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

Medi-Cal (Excludes Pharmacy Requests)

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Routine (Non-Urgent) Pre-Service: Prospective or concurrent service requests where no extension is requested or needed	Approve, modify or deny within 5 working days of receipt of "all information" reasonably necessary and requested to render a decision, and in all circumstances no later than 14 calendar days following receipt of request. "All information" means: Service requested (CPT/HCPC code and description), complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Within 24 hours of the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Dated and postmarked within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.
Routine (Non-Urgent) Pre-Service **Extension Needed** (AKA: Deferral) • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed	Due to a lack of information, for an additional 14 calendar days, under the following conditions: ▪ The member or the member's provider may request for an extension, or the plan can provide justification upon request by the state for the need for additional information and how it is in the member's interest. The delay notice shall include the additional information needed to render the decision, the type of expert needed to review, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.	**Practitioner:** Within 24 hours of the decision, not to exceed 14 calendar days from the receipt of the request	**Practitioner:** Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request. **Member:** Dated and postmarked within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request **Note:** CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
	Additional Requested Information is Received: A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. **Additional information incomplete or not received:** If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.		
Expedited Authorization Requests (Pre-Service): No extension requested or needed. All necessary information received at time of initial request. Requests where a provider indicates, or the plan determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, modify or deny within 72 hours from receipt of request	**Practitioner:** Within 24 hours of making the decision, not to exceed 72 hours from receipt of the request.	**Practitioner:** Within 72 hours of the request. **Member:** Postmarked and mailed within 72 hours from receipt of the request.
Expedited Authorization (Pre-Service) Extension needed: Extension is allowed ***only*** if member or provider requests the extension or the plan justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member.	The plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: ▪ Within 24 hours of receipt of the urgent preservice request, the plan asks the member, the member's representative, or provider for the specific information necessary to make the decision.	**Practitioner and Member:** Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.	**Practitioner**: Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	▪ The plan gives the member or member's authorized representative at least 48 hours to provide the information. ▪ The extension period, within which a decision must be made by the plan, begins: o On the date when the plan receives the member's response (even if not all of the information is provided), ***or*** o At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.		**Member:** Within 2 business days of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination (written notification) **Note:** CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.
	Expedited (Urgent) Pre-Service request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for services where application of the time frame for making routine or non-life-threatening care determinations: o Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or o In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Within 2 working days of making the decision

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
	○ The member or the member's provider may request for an extension, or the health plan/provider group can provide justification upon request by the state for the need for additional information and how it is in the member's interest. ○ Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. ○ Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.		
Concurrent: Concurrent review of treatment regimen already in place, even if the health plan did not previously approve the earlier care (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of the health plan's decision, and a care plan has been agreed	Within 24 hours of receipt of the request **NOTE:** The plan may extend decision time frame if the request to approve additional days for urgent concurrent care is related to care not approved by the plan previously; the plan documents that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to. The plan has up to 72 hours to make a	**Practitioner and Member:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision **Member:** Within 24 hours of making the decision For terminations, suspensions, or reductions of previously authorized services, the plan must notify beneficiaries at least 10 days before the date of the action with the exception of circumstances

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
upon by the treating provider that is appropriate for the medical needs of that member	decision (NCQA UM 5). o A response to defer is required within 24 hours for all services that require prior authorization. o A decision to approve, modify, or deny is required within 72 hours, or as soon as a member's health condition requires, after the receipt of the request. o If the plan is unable to request for an extension of an urgent concurrent care within 24 hours before the expiration of the prescribed period of time or number of treatments, then the plan may treat the request as urgent preservice and make a decision within 72 hours. The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny.		permitted under Title 42, CFR, Sections 431.213 and 431.214.
Post-Service / Retrospective Review: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination (written notification) **Member:** Within 2 business days of the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Post-Service: Extension needed Additional clinical information required	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request. **Additional Information Received:** If requested information is received, decision must be made within 30 calendar days from receipt of request for information. **Additional Clinical Information Incomplete or Not Received:** Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	**Member & Practitioner**: None specified **Member & Practitioner**: None specified **Member & Practitioner**: None specified	**Practitioner / Member:** For ALL Decision Types: Written notice within 30 calendar days from receipt of the information necessary to make the determination.
Hospice - Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Within 24 hours of making the decision **Member:** None Specified	**Practitioner / Member:** Written notice within 2 working days or making the decision.

Medicare (Excludes Pharmacy Requests)

Type of Request	Decision	Notification Timeframe Member and Practitioner
Standard Initial Organization Determination (Pre-Service) If no extension requested or needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) If extension requested or needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	***Extension Notice:*** Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: The reasons for the delay The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The health plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** Must occur no later than expiration of extension.
Expedited Initial Organization Determination If expedited criteria are not met	Promptly decide whether to expedite — determine if: 1. Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2. If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. o If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14-day period begins with the day the request was	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. The written notice must include: 1. Explain that the health plan will automatically transfer and process the request using the 14-day timeframe for standard determinations. 2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	received for an expedited determination.	4. Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination If no extension requested or needed	As soon as medically necessary, within 72 hours after receipt of request (includes weekends and holidays).	Within 72 hours after receipt of request. ▪ **Approvals** o Oral or written notice must be given to member and provider within 72 hours of receipt of request. o Document date and time oral notice is given. o If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** o When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request.
Expedited Initial Organization Determination If extension requested or needed	May extend up to 14 calendar days. Note: Extension allowed only if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers. ▪ When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request).	***Extension Notice:*** Give notice in writing, within 72 hours of receipt of request. The extension notice must include: ▪ The reasons for the delay ▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. ▪ Note: The health plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification*** After an Extension: ▪ Approvals o Oral or written notice must be given to member and provider no later than upon expiration of extension. o Document date and time oral notice is given. If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. ▪ Denials o When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be received by member and provider no later

Type of Request	Decision	Notification Timeframe Member and Practitioner
	▪ Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	than upon expiration of extension.

Pharmacy for Medi-Cal, OC & OCC

Medi-Cal Pharmaceutical — Decision Making	OC and OCC Pharmaceutical — Decision Making
• Processed by CalOptima Pharmacy Management department or Pharmacy Benefits Manager • Qualified pharmacist or physician review for any modifications or denials • Qualified physician review for any appeals	• Processed by CalOptima Pharmacy Management department • Qualified pharmacist or physician review for any modifications or denials • Qualified physician review for any appeals

Medi-Cal Pharmacy Timeframes for Determinations	OC and OC C Pharmacy Timeframes for Determinations (Part D):
Standard (Non-urgent) Preservice: Within 24 hours a decision to approve, modify, deny or defer is required. **Standard (Non-urgent) Preservice, Extension Needed:** Within 5 working days of receiving needed information, but no longer than 14 calendar days **Expedited (Urgent) Preservice/Concurrent:** Within 24 hours a decision to approve, modify, deny or defer is required. **Expedited (Urgent) Preservice/Concurrent, Extension Needed:** Within 72 hours of the initial request **Post-Service/Retrospective:** Within 30 days of receipt	• Routine: 72 hours • Urgent: 24 hours • Retrospective: 14 days

Medi-Cal Pharmacy Timeframes for Notification	OC and OCC Pharmacy Timeframes for Notification (Part D)
Pre-Service and Concurrent Approvals: Provider: Electronic/written: Within 24 hours of making the decision. **Pre-Service and Concurrent Denials:** Provider: Electronic/written: Within 24 hours of making the decision. Member: Written: Within 2 business days of making the decision. **Post Service/ Retrospective Approvals:** Practitioner: Written: Within 30 days of receipt of request. **Post Service/ Retrospective Denials:** Practitioner: Written: Within 30 days of receipt of request. Member: Written: Within 30 days of receipt of request.	Authorization Request Type: **For expedited requests**: Written notification must be provided to the member within 24 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification. **For standard requests**: Written notification must be provided to the member within 72 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification. **For retrospective requests:** Written notification must be provided to the member within 14 calendar days from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.

Emergency Services

Emergency room services are available 24 hours per day, 7 days per week. Prior authorization is not

required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition. CalOptima covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Services

A hospital must submit a Prior Authorization Request for Post-Stabilization Services when a member who has received emergency services for an emergency medical condition is determined to have reached medical stability, but requires additional, medically necessary inpatient covered services that are related to the emergency medical condition, and provided to maintain, improve or resolve the member's stabilized medical condition.

CalOptima or a HN shall approve or deny within 30 minutes after receiving a prior authorization request for post- stabilization services and all information reasonably necessary and requested to render a decision from a hospital for Medi-Cal members, , and within 60 minutes after receiving such request and information from a hospital for OC or OCC members. If CalOptima or the HN does not respond within the prescribed time frame, medically necessary post-stabilization services are considered approved.

PRIOR AUTHORIZATION SERVICES

UM Urgent/Expedited Prior Authorization Services

For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima at least 5 days prior to the requested service date. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. Prior authorization is never required for emergency or urgent care services.

UM Routine/Standard Prior Authorization Services

CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within 5 business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request for Medi-Cal members and within 14 calendar days for OC/OCC.

Retrospective Review

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director, UM or designee, reviews the request for retrospective authorization. Retrospective Authorization shall only be permitted in accordance with CalOptima Policy and Procedure GG.1500 Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director, UM or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Concurrent Review Process

In addition to authorization for post-stabilization services that often result in an inpatient admission, facilities are also required to notify CalOptima of all inpatient admissions within 1 business day following the admission. The admission/concurrent review process assesses the clinical status of the member, verifies the need for continued hospitalization, facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed
- Validating the diagnosis
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures proposed
- Reasons for extension of the treatment or service

A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre- service and post-service).

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonically. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment, and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight certified mail to the attending physician, hospital and the member.

The need for case management or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima QI department for investigation and resolution.

Discharge Planning Review

Discharge planning begins within 48 hours of an inpatient admission and is designed to identify and initiate a cost effective, quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.
Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member’s care.
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Concurrent Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial or termination of any service based on medical necessity or benefit limitations. Upon any adverse determination for medical or behavioral health services made by a CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the time frames as noted in GG.1508 Authorization and Processing of Referrals. The written notification is written in lay language that is easily understandable at the 6th grade level and includes the member specific reason/rationale for the determination, specific

criteria and availability of the criteria used to make the decision as well as the availability, process and time frames for appeal of the decision. All templates for written notifications of decision making are DHCS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Medical Director or appropriate practitioner reviewer (BH practitioner, pharmacist, etc.) serves as the point of contact for the peer to peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

GRIEVANCE AND APPEAL PROCESS

CalOptima has a comprehensive review system to address matters when Medi-Cal, OC or OC C members wish to exercise their right to review a UM decision to deny, delay, or modify a request for services, or terminate a previously-approved service. This process is initiated by contact from a member, a member's representative, or practitioner to CalOptima. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima's Grievance and Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.
The grievance process is in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Policy GG.1510: Appeal Process. This process includes:

- Collection of information and/or medical records related to the grievance or appeal.
- Communication to the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for COD, HMOs, PHCs and SRGs is handled by CalOptima GARS. CalOptima works collaboratively with the delegated entity in the gathering of information and supporting documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the California Department of Social Services. Grievances and appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer, other than the reviewer who made the initial denial determination. The UM or CM Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The UM or CM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board-Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

Upon request, members can have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Customer Service department.

Expedited Grievances

A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt. At the time of the request, the information is reviewed, and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality.

State Hearing

CalOptima Medi-Cal members have the right to request a State Hearing from the California Department of Social Services after exhausting the appeal process. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

OC and OCC members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima is notified when a request is made by a member or member representative. CalOptima supports the process with providing the medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima of the outcome of their review. If the decision is overturned, CalOptima complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals.
2. Other provider-preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima's QI department for further research and reporting to government and/or regulatory agencies.

LONG-TERM SERVICES AND SUPPORTS

LTC

The LTC case management program includes authorizations for the following facilities:

- NF-A and NF-B, sub-acute care

It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, congregate living health facilities and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days. There are two types of NFs: Onsite NFs where nurses make monthly or bi-monthly visits, and "FAX-IN" NFs (includes all out of county NFs) where NCMs do not visit but do review medical records sent to them via email or fax. Either an on-site visit or FAX-IN process is scheduled to assess a member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes, as well as bedside evaluation of the member and support system (for onsite only). Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS or to a CBAS facility. Referrals to case management can also be made upon discharge when member needs indicate a referral is appropriate. In addition, the LTC staff provides education to facilities and staff through monthly onsite visits, quarterly and annual workshops, or in response to individual facility requests, and when new programs are implemented.

CBAS

An outpatient, facility-based program offering day-time care and health and social services, to frail seniors and adults with disabilities to enable participants to remain living at home instead of in a nursing facility. Services may include: health care coordination; meal service (at least one per day at center); medication management; mental health services; nursing services; personal care and social services; physical, occupational, and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center.

MSSP

CalOptima has responsibility for the payment of the MSSP in the County of Orange for individuals who have Medi-Cal. The program provides services and support to help persons 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to, senior center programs; case management; money management and counseling; respite; housing assistance; assistive devices; legal services; transportation; nutrition services; home health care; meals; personal care assistance with hygiene; personal safety; and activities of daily living.

Transitions of Care

Transitions of Care (TOC) is a patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides OC and OCC members

discharged from Fountain Valley Regional Hospital (or their caregivers) with tools and support to encourage and sustain self-management skills in an effort to minimize the potential of a readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:

- **Knowledge of Red Flags**: Member is knowledgeable about indications that their condition is worsening and how to respond.
- **Medication Self-Management**: Member is knowledgeable about medications and has a medication management system.
- **Patient-Centered Health Record (PHR)**: Member understands and uses a PHR to facilitate communication with their health care team and ensure continuity of care across providers and settings.
- **Physician Follow-Up**: Member schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Case Management Process

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable. For further details of the structure, process, staffing, and overall program management please refer to the 2019 Case Management Program document.

Transplant Program

The CalOptima Transplant Program is coordinated by the Medical Director and Medi-Cal members are managed in collaboration with the Case Management department. Transplants for Medi-Cal only members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan. The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician, and facilities are assisted in order to assure timely, efficient, and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant staff, and the facilities. CalOptima monitors and maintains oversight of the Transplant Program.

Coordination of Care

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit

limitation. Because Medi-Cal is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider in certain situations. CalOptima also coordinates continuity of care with other Medicaid health plans when a new member comes into CalOptima or a member terminates from CalOptima to a new health plan.

Over/Under Utilization

Over/under utilization monitoring is tracked by UM and reported to UMC. Measures are monitored and reviewed for over and underutilization, and/or changes in trends. Actions are determined based on trends identified and evaluated for effectiveness.

The following are measures tracked and monitored for over/under utilization trends:

- ER admissions
- Bed Days
- Admits per 1000
- Average Length of Stay
- Readmission Rates
- Denial Rates
- Pharmacy Utilization Measures
- Overturn Rates — Provider per 1000 per Year
- Select HEDIS rates for selected measures
- Other areas as identified

PROGRAM EVALUATION

The UM Program is evaluated at least annually, and modifications made as necessary. The UM Medical Director and Director, UM evaluate the impact of the UM Program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- (DUR profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIC and QAC for approval.

SATISFACTION WITH THE UM PROCESS

CalOptima provides an explanation of the GARS process, Fair Hearing, and Independent Review

processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers, and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima QI department for investigation and resolution.

Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include, but are not limited to: member satisfaction survey results such as Consumer Assessment of Healthcare Providers and Systems (CAHPS); member/provider complaints and appeals that relate specifically to UM; provider satisfaction surveys with specific questions about the UM process; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, CalOptima develops an action plan and interventions to improve on the areas of concern which may include staff retraining and member/provider education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
8. Consider Approval of the CalOptima Fiscal Year 2020-21 Operating Budget

Contact
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions
1. Approve the CalOptima Fiscal Year (FY) 2020-21 Operating Budget; and
2. Authorize the expenditures and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy.

Background
The CalOptima FY 2020-21 Operating Budget provides revenues and appropriations for the period of July 1, 2020, through June 30, 2021, and includes the following budget categories:

- Medi-Cal;
- OneCare Connect;
- OneCare;
- Program for All-Inclusive Care for the Elderly (PACE);
- Multipurpose Senior Services Program (MSSP);
- Facilities; and
- Investment income.

Staff is submitting the complete budget for all lines of business for approval with assumptions based on available information to date. Pursuant to CalOptima Policies GA.3202: CalOptima Signature Authority, GA.5002: Purchasing Policy, and GA.5003: Budget and Operations Forecasting, the Board's approval of the budget authorizes the expenditure and appropriates the funds requested for the item without further Board action to the extent the Board has or is, as indicated in the budget attachments, delegating authority to Management.

The primary revenue source is the State of California. The COVID-19 pandemic has led to a national recession, sharp decline in state revenues, and rapid increases to health and human services caseloads and medical expenses. On May 14, 2020, the Governor released the revised state budget (May Revise) that projects a budget deficit of approximately $54.3 billion for FY 2019-20 and FY 2020-21 combined. The Governor's budget proposes to close this gap with a combination of (1) cancelled expansions and other reductions; (2) reserves; (3) borrowing, transfers, and deferrals; (4) new revenues; (5) federal funds; and (6) trigger cuts, if federal funding does not materialize.

The May Revise contains several proposals that will impact CalOptima's lines of business directly.

- New budget proposals in the May Revise
    - 1.5% rate reduction for the Medi-Cal managed care rates from July 1, 2019, through December 31, 2020 (i.e., Bridge Period). DHCS will implement a risk corridor; and

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  - Managed care capitation rate adjustments effective for rate year beginning January 1, 2021. DHCS will make acuity, efficiency and cost containment downward revenue adjustments.

- Cancelled expansions or other reductions from January Budget
  - Delayed implementation of CalAIM; DHCS noted the Whole Person Care pilot and Health Homes Program will continue as authorized;
  - Cancelled Medi-Cal eligibility expansion to undocumented adults 65 and older; and
  - Cancelled Medi-Cal eligibility expansion to seniors and persons with disabilities (SPD) with incomes between 123% and 138% FPL.

- Trigger cuts, if federal funding does not materialize
  - Reduce adult dental benefits to partial restoration levels in 2014;
  - Eliminate Medi-Cal optional benefits;
  - Eliminate CBAS effective 1/1/21;
  - Eliminate MSSP effective 7/1/20; and
  - Shift $1.2B in Proposition 56 funding to pay for Medi-Cal program caseload growth effective July 1, 2020.

The State Legislature is required to pass a balanced budget by June 15, 2020. CalOptima will have a high level of uncertainty until the final budget is passed. Staff has included the new budget proposals from the May Revise and cancelled expansions or other reductions from the Governor's January Budget in the current Operating Budget. At this time, the Newsom Administration has not provided a timeline for when they will decide on the proposed trigger cuts. Staff will continue to monitor the discussions between the Legislature and Newsom Administration to assess the likelihood of implementation.

Given the current COVID-19 environment, CalOptima staff continues to work to protect the health and safety of our members and to preserve Orange County's safety net health system. The proposed FY 2020-21 Consolidated CalOptima Operating Budget reflects management's efforts to balance state funding constraints while upholding CalOptima's mission to ensure member access to quality care.

At the May 21, 2020, meeting, the CalOptima Finance and Audit Committee did not take action on the FY 2020-21 Operating Budget. Members discussed the general and administrative expenses in the proposed budget in light of the current job environment. They instructed staff to remove or reduce salary-related expenses, increase the vacancy factor, and review non-salary expenses to identify any additional areas where further reductions were possible. Staff was instructed to bring a revised budget to the June 4, 2020, meeting for the full Board to consider.

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CalOptima Budget Overview

I. Consolidated Operating Budget

The FY 2020-21 Consolidated Operating Budget is a combined income and spending plan for all CalOptima programs and activities.

Table 1: FY 2020-21 Consolidated Operating Budget

	FY 2020-21 Budget
Average Monthly Enrollment	800,302
Revenue	$3,555,013,609
Medical Costs	$3,458,653,648
Administrative Expenses	$151,426,274
Operating Income/Loss	**($55,066,313)**
Investments, Net	$15,000,000
Change in Net Assets	**($40,066,313)**
Medical Loss Ratio (MLR)	97.3%
Administrative Loss Ratio (ALR)	4.3%

Budget Assumptions

Medical Cost: Several methods were utilized to develop the medical cost forecasts. Predominantly, projections were based on trends calculated from historical experience. In addition, adjustments were applied to account for known changes to operations, program structure, benefits, and regulatory policies. For newly implemented programs, staff used historical data, proxy data and industry benchmarks, and checked results for reasonability.

Administrative Expenses: To take into consideration seasonal and cyclical spending patterns, FY 2020-21 was forecasted utilizing a 12-month historical run-rate. To ensure inclusion in the budget, Staff reviewed all contract encumbrances. Lastly, internal departments identified resource requirements based on changes to enrollment, regulatory and organizational needs. Staff considered:

- Salaries, Wages & Benefits for current staff, unfilled budgeted positions and new budgeted positions;
- Professional Fees, Purchased Services, Printing & Postage and Other Operating Costs based on the needs and priorities of providing care to members;
- Depreciation & Amortization on current assets and projected assets according to Generally Accepted Accounting Principles (GAAP); and
- Indirect Cost Allocation primarily based on revenue and adjusted where necessary.

Of note, CalOptima has several contracts for claims administration, credit balance recovery, and Social Security Income conversion that are paid on a contingency basis. The following table provides a comparison of consolidated general and administrative expenses from the budgeted and previous fiscal years.

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Table 2: Comparison of Consolidated General and Administrative Expenses

	FY 2018-19 Actual	FY 2019-20 Forecast*	FY 2020-21 Budget	FY 2020-21 Budget vs. FY 2019-20 Forecast
Revenues	$3,474,634,378	$3,642,286,855	$3,555,013,609	($87,273,246)
Salaries, Wages & Benefits	**$84,008,424**	**$88,405,275**	**$95,697,295**	**$7,292,020**
Non-Salaries	**$45,940,773**	**$45,987,131**	**$55,728,979**	**$9,741,848**
Professional Fees	$3,167,619	$3,212,922	$4,432,100	$1,219,178
Purchased Services	$12,584,719	$12,272,285	$14,698,659	$2,426,374
Printing & Postage	$5,212,810	$4,964,763	$6,838,770	$1,874,007
Depreciation & Amortization	$7,226,723	$6,007,358	$7,653,840	$1,646,482
Other Operating Exp/Indirect Cost Allocation, Occupancy	$17,748,901	$19,529,803	$22,105,610	$2,575,807
Total G&A	**$129,949,196**	**$134,392,406**	**$151,426,274**	**$17,033,868**
ALR	3.7%	3.7%	4.3%	0.6%
ALR Breakdown:				
Salaries, Wages & Benefits	2.4%	2.4%	2.7%	0.3%
Non-Salaries	1.3%	1.3%	1.6%	0.3%

* Forecasted as of March 2020; Revenue excludes directed payments
Note: FY 2019-20 forecasted figures do not include unfilled open positions

Attachment B: Administrative Budget Details provides additional information regarding all general and administrative expenses included in the FY 2020-21 Operating Budget.

II. Enrollment by Line of Business

The following table provides a comparison of total average enrollment for the past two (2) fiscal years with the projected enrollment for FY 2020-21.

Table 3: Total Enrollment by Program

Program[1]	FY 2018-19 Actual[2]	FY 2019-20 Forecast[2]	FY 2020-21 Budget[2]	% Change 21 v. 20
Medi-Cal	739,858	744,413	800,875	7.6%
OneCare Connect	14,201	14,159	13,843	-2.2%
OneCare	1,535	1,378	1,378	0.0%
PACE	327	401	472	17.7%
Total	**755,921**	**760,351**	**816,568**	**7.4%**

[1]MSSP enrollment included in Medi-Cal
[2]Enrollment as of June of every fiscal year when available

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III. Operating Budget by Line of Business

A. Medi-Cal Program

Through a contract with the California Department Health Care Services (DHCS), CalOptima has administered the Medi-Cal program for Orange County since October 1995. CalOptima's current contract expires on December 31, 2020. The table below illustrates the Consolidated Medi-Cal Operating Budget.

Table 4: FY 2020-21 Medi-Cal Consolidated Operating Budget

	FY 2018-19 Actual	FY 2019-20 Forecast*	FY 2020-21 Budget
Average Monthly Enrollment	751,409	721,719	784,502
Revenue	$3,134,181,617	$3,289,166,019	$3,185,809,324
Medical Costs	$2,881,181,629	$3,144,826,354	$3,104,736,697
Administrative Expenses	$106,944,388	$111,931,109	$127,905,486
Operating Income/Loss	$146,155,600	$32,408,556	($46,832,859)
MLR	92.0%	95.6%	97.5%
ALR	3.4%	3.4%	4.0%

* Forecasted as of March 2020; Revenue excludes directed payments
Change in net assets excludes net investment and other income
Includes MSSP from July to December 2020

For FY 2020-21, Medi-Cal membership is comprised of three (3) main categories: Classic, Expansion, and Whole Child Model (WCM). The following table illustrates the Medi-Cal Operating Budget by each of these categories.

Table 5: FY 2020-21 Medi-Cal Operating Budget by Group

	Medi-Cal Classic	Medi-Cal Expansion	Medi-Cal WCM	Total
Average Monthly Enrollment	521,582	250,988	11,931	784,502
Revenue	$1,706,161,985	$1,228,272,960	$251,374,380	$3,185,809,324
Medical Costs	$1,670,526,238	$1,183,867,064	$250,343,395	$3,104,736,697
Administrative Expenses				$127,905,486
Operating Income/Loss				($46,832,859)
MLR	97.9%	96.4%	99.6%	97.5%
ALR				4.0%

DHCS uses Category of Aid (COA) to classify Medi-Cal enrollment into cohorts of similar acuity. DHCS develops CalOptima's capitation rates based on these cohorts. The following table shows the projected enrollment distribution by COA.

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Table 6: FY 2020-21 Medi-Cal Enrollment Projection

	FY 2019-20 Forecast*	FY 2020-21 Budget*	Variance	
			Diff	%
BCCTP	498	460	(38)	-7.6%
Disabled	44,811	44,804	(8)	0.0%
Long Term Care	3,503	3,527	24	0.7%
Aged	65,927	66,404	477	0.7%
Child (TANF ≤ 18)	292,233	320,582	28,349	9.7%
Adult (TANF > 18)	88,003	96,335	8,331	9.5%
Medi-Cal Classic Subtotal	**494,975**	**532,111**	**37,136**	**7.5%**
Medi-Cal Expansion	237,506	256,832	19,326	8.1%
WCM	11,931	11,931	-	0.0%
TOTAL	**744,413**	**800,875**	**56,462**	**7.6%**

* Enrollment as of June of every fiscal year; figures may not add due to rounding

General Budget Assumptions – Medi-Cal

DHCS will implement several policy and program changes during FY 2020-21 that will directly impact CalOptima's revenues and medical expenses. The following initiatives have been considered in the budget:

- Delayed implementation of CalAIM;
- Carve-out of prescription drug benefit effective January 1, 2021, including Hepatitis C medications;
- Expansion of Proposition 56 directed payments program;
- Expansion of the Health Homes Program; and
- Carve-out of MSSP program effective January 1, 2021.

Enrollment: Enrollment projections are based on actual data through March 2020 and trended through June 2021. Because of the effects on personal income from the COVID-19 pandemic, the budget assumes an increase in Temporary Assistance for Needy Families (TANF) (Adult and Child) and the Medi-Cal Expansion members.

Revenue: DHCS will transition its rate year to begin on January 1, instead of July 1. With this change, Staff applied the draft 18-month bridge period rates received in March 2020 for the period of July 1, 2020, through December 31, 2020 adjusted for the 1.5% rate reduction of the Medi-Cal managed care base rates per the Governor's May Revise. Staff anticipates receipt of Calendar Year (CY) 2021 draft rates in October 2020. As such, Staff has forecasted capitation rates for the period of January 1, 2021, through June 30, 2021, based on available information.

Medical Cost: The budget anticipates the following trends in benefits for FY 2020-21:

- Increase in Non-Medical Transportation (NMT) utilization;
- Expansion of vision benefits and higher administration fee;
- Increase in unit cost for Skilled Nursing Facilities;
- Increase in unit cost for Mental Health Services;

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- Increase in Pay for Value (P4V) program funding; and
- Increase in Obstetrics supplemental payments.

Medi-Cal Classic
Classic Enrollment: The budget projects an 8.0% increase in total member months.

Classic Revenue: The budget estimates that base rates effective January 2021 will be reduced by an additional 3% to account for potential acuity, efficiency and cost containment adjustments in the Governor's May Revise.

Classic Medical Cost: Provider capitation payments were based on capitation rates and enrollment distribution as of March 2020. Milliman, CalOptima's actuarial consultant, completed a rebasing analysis to update capitation rates and rate structure to Health Networks for the Medi-Cal Classic population. The results of this analysis are included in the rate adjustments effective July 1, 2020.

Fee-for-service (FFS) costs were based on historical claims trended to June 2021, and were developed by network type, COA, and category of service.

Table 7: Updates to Provider Reimbursement Rates for Classic Members

Medical Cost	Unit Cost Change	Detail
Provider Capitation	Decrease (-2.0%)	Average adjustment for both TANF and SPD categories of aid • Child: -12.8% • Non-Child: +7.2%
Skilled Nursing Facility	Increase	Includes +20% unit cost trend increase approved in the FY 2019-20 Operating Budget
Ancillary Provider Rate	Increase	• Mental health (Non-ABA): +15% unit cost increase for fee schedule change • Obstetrics: +13% increase
P4V Program	Increase	From $2.00 PMPM maximum to $5.00 PMPM maximum

Medi-Cal Expansion
Expansion Enrollment: The budget projects a 9.5% increase in total member months.

Expansion Revenue: DHCS continues to make material adjustments to the Medi-Cal Expansion capitation rate. The budget estimates that base rates effective January 2021 will be reduced by an additional 5% to account for potential acuity, efficiency and cost containment adjustments in the Governor's May Revise.

Expansion Medical Cost: Provider capitation payments were reduced 7% for Professional services and 14% for Hospital services. Milliman completed a rebasing analysis to update capitation rates to Health

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Networks for the Medi-Cal Expansion population. The results of this analysis support the rate adjustments effective July 1, 2020. The budget also assumes the implementation of Chronic Illness and Disability Payment System (CDPS) risk adjustment effective July 1, 2020.

FFS cost trends were developed by network type, COA, and category of service. Staff maintained current FFS reimbursement levels for inpatient hospital, clinic, primary care and specialist contract rates. The budget includes projected expenses for quality improvement programs.

Table 8: Updates to Provider Reimbursement Rates for Expansion Members

Medical Cost	Unit Cost Change	Detail
Provider Capitation	Decrease (-10.6%)	• Professional: -7% • Hospital: -14%
Skilled Nursing Facility	Increase	Includes +20% unit cost trend increase approved in the FY 2019-20 Operating Budget
Ancillary Provider Rate	Increase	• Mental health (Non-ABA): +15% unit cost increase for fee schedule change • Obstetrics: +13% increase
P4V Program	Increase	From $2.00 PMPM maximum to $5.00 PMPM maximum

Medi-Cal Whole Child Model
WCM Enrollment: The budget projects enrollment will remain relatively flat.

WCM Revenue: The budget assumes that rates will increase by 5.7% in January 2021. Rates reflect reimbursement for both California Children's Services (CCS) and non-CCS services.

WCM Medical Cost: Staff has begun analyzing experience data for the WCM population as it becomes available. Staff continues to utilize draft rates as a proxy for actual experience. CalOptima provides capitation with a risk corridor to Health Networks. The budget assumes that the primary drivers for higher than expected medical costs within the WCM population are due to expenses within Facilities, LTC, and Pharmacy services.

B. OneCare Connect
Through a three-way contract with the Center for Medicare & Medicaid Services (CMS), DHCS, and CalOptima, CalOptima began the OneCare Connect Program in July 2015. The Cal MediConnect program is a joint Medicare and Medicaid demonstration program that promotes coordinated health care delivery to SPD members who are dually eligible for Medicare and Medi-Cal services. The initial demonstration period was October 1, 2013, through December 31, 2019. On April 24, 2019, CMS approved a three (3) year extension of the program through December 31, 2022. The table below illustrates the OneCare Connect Operating Budget.

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Table 9: FY 2020-21 OneCare Connect Operating Budget

	FY 2018-19 Actual	FY 2019-20 Forecast*	FY 2020-21 Budget
Average Monthly Enrollment	14,398	14,415	13,988
Revenue	$292,428,410	$296,342,072	$306,323,384
Medical Costs	$293,947,462	$286,650,446	$297,562,629
Administrative Expenses	$19,863,775	$18,706,540	$19,441,298
Operating Income/Loss	($21,382,827)	($9,014,914)	($10,680,544)
MLR	100.5%	96.7%	97.1%
ALR	6.8%	6.3%	6.3%

* Forecasted as of March 2020

General Budget Assumptions – OneCare Connect

Enrollment: Average OneCare Connect membership is projected to decline by approximately 1.5% from FY 2019-20 through FY 2020-21.

Revenue: The FY 2020-21 Operating Budget utilizes the most current county benchmark base rates from CY 2020 for Medicare Parts C and D. Rates were not developed from a bid process that uses actual plan data. Staff assumed a 0.7% increase to Part C revenue and a 2% decrease to Part D revenue effective January 2021. The budget includes a small increase to Part D revenue from the projected Risk Adjustment Factor (RAF) score. The budget includes a Year 3+ savings target of 5.5% and a quality withhold of 4.0%. A suspension of the 2% sequestration reduction from July 1, 2020, through December 31, 2020, has been accounted for, and assumes the reduction will resume on January 1, 2021. In addition, disenrollment rate penalties will continue to apply.

Staff applied Medi-Cal CY 2019 draft rates from DHCS and adjusted forecasted enrollment in the specified population cohorts. The budget includes lower Medi-Cal revenue due to a decrease in Long Term Care (LTC) enrollment. The final Medi-Cal revenue will be adjusted to reflect the actual population mix.

Medical Cost: Provider capitation payments were based on Percent of Premium (POP) rates for the Medicare component and fixed per member per month (PMPM) rates for the Medi-Cal component. Milliman completed a rebasing analysis on Health Network POP percentages. Since the program began in 2015, the POP rates had remained unchanged. The budget includes adjustments to the Institutional capitation rate from 50.9% to 45% beginning January 1, 2021.

FFS expenses were projected based on actual OneCare Connect experience, trended through June 2021. Staff applied the projected enrollment mix for Physician Hospital Consortia (PHC), Shared Risk Groups (SRG), Health Maintenance Organizations (HMO), and the CalOptima Community Network (CCN). The budget includes projected increases in NMT utilization, specialist services, acute inpatient facility utilization, pharmacy and a decrease in LTC expenses. It also includes costs for MLTSS services, as well as quality improvement programs. Approved existing and new supplemental benefits effective January 2021, such as an enhanced Part D benefit, increased coverage for emergency room (ER) services worldwide, and an increased allowance for over-the-counter drugs are also included.

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C. OneCare

Through a contract with the CMS, CalOptima has administered a Medicare Advantage Dual Eligible Special Needs Plan since October 2005. CalOptima's current contract expires on December 31, 2020. OneCare will continue to provide services for beneficiaries not eligible for the OneCare Connect program. The table below illustrates the OneCare Operating Budget.

Table 10: FY 2020-21 OneCare Operating Budget

	FY 2018-19 Actual	FY 2019-20 Forecast*	FY 2020-21 Budget
Average Monthly Enrollment	1,448	1,481	1,378
Revenue	$20,613,605	$20,496,838	$19,472,782
Medical Costs	$18,272,702	$18,295,185	$17,827,723
Administrative Expenses	$1,375,766	$1,710,002	$1,646,834
Operating Income/Loss	$965,137	$491,651	($1,774)
MLR	88.6%	89.3%	91.6%
ALR	6.7%	8.3%	8.5%

* Forecasted as of March 2020

General Budget Assumptions – OneCare

Enrollment: Average OneCare membership is projected to decrease approximately 5.4% from FY 2019-20 through FY 2020-21.

Revenue: Staff based Medicare Parts C and D rates on CY 2020 Monthly Membership Report (MMR) actuals. The budget includes a 4.0% decrease to Part C base rates effective January 2021 due to the projected decrease in utilization included in the CY 2021 bid submission. Staff anticipates Part D revenue approximately 6.0% higher than prior year assumptions primarily due to a higher RAF score. A suspension of the 2% sequestration reduction from July 1, 2020, through December 31, 2020, has been accounted for, and assumes the reduction will resume on January 1, 2021.

Medical Cost: Professional provider capitation payments were based on an average 38.6% POP, inclusive of quality incentive payments. FFS medical costs were based on historical claims incurred through February 2020. The budget includes a 5.4% inpatient trend and a 1.7% increase in pharmacy costs from FY 2019-20 through FY 2020-21. In addition, the budget includes expenses for approved existing and new supplemental benefits effective January 2021, such as enhanced Part D benefit, increased coverage for ER services worldwide, and an increased allowance for over-the-counter drugs.

D. PACE

Through a contract with CMS, CalOptima began Orange County's first PACE program on October 1, 2013. The PACE contract is renewed through one-year extensions. CalOptima's current contract expires on December 31, 2020. The PACE program provides coordinated care for persons age 55 and older who need a higher level of care to remain in their homes. The table below illustrates the PACE Operating Budget.

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Table 11: FY 2020-21 PACE Operating Budget

	FY 2018-19 Actual	FY 2019-20 Forecast*	FY 2020-21 Budget
Average Monthly Enrollment	303	374	434
Revenue	$27,410,747	$36,281,926	$42,189,583
Medical Costs	$23,297,733	$29,410,640	$37,731,523
Administrative Expenses	$1,765,267	$2,044,756	$2,002,647
Operating Income/Loss	$2,347,747	$4,826,530	$2,455,414
MLR	85.0%	81.1%	89.4%
ALR	6.4%	5.6%	4.7%

* Forecasted as of March 2020

Though PACE continues to run efficiently, Management will continue to focus on several areas of opportunities to improve the PACE program, including:

- Continue implementation of service area expansion through Alternative Care Settings (ACS) for improved member access;
- Ensure accurate reporting of experience and cost data through the Rate Development Template filing;
- Improve medical cost containment efforts;
- Implement initiatives to gain greater administrative efficiencies and operational economies of scale; and
- Improve coding and submission of diagnostic data.

General Budget Assumptions – PACE

Enrollment: Due to the COVID-19 pandemic, the budget forecasts flat enrollment growth from the current through July 2020, growth by 4 members per month for August and September 2020, and a return to growth of 7 members per month from October 2020 through June 2021. Enrollment is forecasted to end at 472 members by June 2021. The member population is projected to consist of 48% dual eligible members and 52% Medi-Cal only members.

Revenue: The budget applies rates from CY 2020 actuals for Medicare Parts C and D, and projects a 7.1% increase to Part C base rates effective January 2021. Medicare Part D rates and subsidies were based on CY 2020 payments. No additional trend assumptions were applied. Medi-Cal PMPM rates reflect a 2.2% increase and are based on CY 2019 rates provided by DHCS on December 13, 2019. A suspension of the 2% sequestration reduction from July 1, 2020, through December 31, 2020, has been accounted for, and assumes the reduction will resume on January 1, 2021.

Medical Cost: Medical costs were projected using actual experience. The budget includes sufficient utilization trends in Community-Based Adult Services due to ACS enrollment, dialysis, professional specialist services, transportation and pharmacy utilization. Staff reclassified 96% of some administrative expenses as medical costs to better reflect the actual costs of delivering medical care.

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E. Investment Income

The table below illustrates projected net investment income.

Table 12: Investment Income

	FY 2018-19 Actual	FY 2019-20 YTD Forecast*	FY 2020-21 Budget
Investment Income	$43,639,175	$38,925,807	$15,000,000

* Forecasted as of March 2020

Budget Assumptions – Investment Income

The FY 2020-21 Operating Budget projects $15,000,000 in net investment income. The budget is lower than the FY 2019-20 Forecast due to the uncertainty of COVID-19's impact on the value of CalOptima's portfolio and the projected return on investments in FY 2020-21.

Fiscal Impact

As outlined above and more in the additional detail contained in Attachment A: FY 2020-21 Budget for all Lines of Business, the FY 2020-21 Operating Income reflects a projected loss of $55.1 million. In addition, the budget includes projected investment income of $15 million, resulting in a projected total decrease of $40.1 million in net assets. Management proposes to use reserves to address the projected FY 2020-21 budget shortfall.

Rationale for Recommendation

Management submits the FY 2020-21 Operating Budget for all program areas using the best available assumptions to provide health care services to CalOptima's forecasted enrollment.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Attachment A: FY 2020-21 Budget for all Lines of Business
Attachment B: Administrative Budget Details

/s/ Richard Sanchez — *05/27/2020*
Authorized Signature — **Date**

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Attachment A

CalOptima Fiscal Year 2020-21 Budget
By Line of Business

	Medi-Cal (Classic)	Medi-Cal (Expansion)	Medi-Cal (WCM)	Total	OCC	OneCare	PACE	MSSP	Facilities	Consolidated
Member Months	6,258,987	3,011,857	143,178	9,414,022	167,856	16,536	5,211	2,730	-	**9,603,625**
Avg Members	521,582	250,988	11,931	784,502	13,988	1,378	434	455	-	**800,302**
Revenues										
Capitation revenue	$ 1,706,161,985	$ 1,228,272,960	$ 251,374,380	$ 3,185,809,324	$ 306,323,384	$ 19,472,782	$ 42,189,583	$ 1,218,536	$ -	$ **3,555,013,609**
Total	$ 1,706,161,985	$ 1,228,272,960	$ 251,374,380	$ 3,185,809,324	$ 306,323,384	$ 19,472,782	$ 42,189,583	$ 1,218,536	$ -	$ **3,555,013,609**
Medical Costs										
Provider capitation	$ 525,065,237	$ 544,737,283	$ 101,059,284	$ 1,170,861,804	$ 132,514,946	$ 5,220,667	$ -	$ -	$ -	$ **1,308,597,418**
Claims Payments	$ 557,986,264	$ 422,990,239	$ 97,076,012	$ 1,078,052,514	$ 59,102,790	$ 6,184,669	$ 18,272,209	$ -	$ -	$ **1,161,612,182**
LTC/Skilled Nursing Facilities	$ 432,568,164	$ 37,233,712	$ 13,282,179	$ 483,084,055	$ 18,145,318	$ -	$ 826,406	$ 158,410	$ -	$ **502,214,188**
Prescription Drugs	$ 103,242,805	$ 143,275,777	$ 34,466,289	$ 280,984,871	$ 70,776,758	$ 5,897,339	$ 3,427,259	$ -	$ -	$ **361,086,227**
Case Mgmt & Oth Medical	$ 51,663,768	$ 35,630,054	$ 4,459,631	$ 91,753,453	$ 17,022,816	$ 525,047	$ 15,205,649	$ 636,667	$ -	$ **125,143,633**
Total	$ 1,670,526,238	$ 1,183,867,064	$ 250,343,395	$ 3,104,736,697	$ 297,562,629	$ 17,827,723	$ 37,731,523	$ 795,076	$ -	$ **3,458,653,648**
MLR	*97.9%*	*96.4%*	*99.6%*	*97.5%*	*97.1%*	*91.6%*	*89.4%*	*65.2%*		*97.3%*
Gross Margin	$ 35,635,746	$ 44,405,895	$ 1,030,985	$ 81,072,627	$ 8,760,755	$ 1,645,059	$ 4,458,061	$ 423,459	$ -	$ **96,359,961**
Administrative Expenses										
Salaries, Wages, & Employee Benefits				$ 83,409,902	$ 9,604,947	$ 812,160	$ 1,524,159	$ 346,127	$ -	$ **95,697,295**
Professional Fees				$ 3,752,802	$ 481,000	$ 192,000	$ 2,000	$ 4,298	$ -	$ **4,432,100**
Purchased services				$ 12,467,137	$ 1,240,950	$ 117,000	$ 213,324	$ 248	$ 660,000	$ **14,698,659**
Printing & Postage				$ 5,320,902	$ 1,278,220	$ 97,000	$ 140,400	$ 248	$ 2,000	$ **6,838,770**
Depreciation & Amortization				$ 5,502,000	$ -	$ -	$ 24,840	$ -	$ 2,127,000	$ **7,653,840**
Other Operating Expenses				$ 20,029,432	$ 194,275	$ 6,450	$ 42,670	$ 47,890	$ 2,094,000	$ **22,414,717**
Indirect Cost Allocation, Occupancy Expense				$ (2,576,689)	$ 6,641,906	$ 422,224	$ 55,254	$ 31,198	$ (4,883,000)	$ **(309,107)**
Total				$ 127,905,486	$ 19,441,298	$ 1,646,834	$ 2,002,647	$ 430,009	$ -	$ **151,426,274**
ALR				*4.0%*	*6.3%*	*8.5%*	*4.7%*	*35.3%*		*4.3%*
Operating Income/(Loss)				$ (46,832,859)	$ (10,680,544)	$ (1,774)	$ 2,455,414	$ (6,550)	$ -	$ **(55,066,313)**
Investment Income										$ 15,000,000
MCO Tax Revenue				$ 182,255,794						$ 182,255,794
MCO Tax Expense				$ (182,255,794)						$ (182,255,794)
CHANGE IN NET ASSETS				$ **(46,832,859)**	$ **(10,680,544)**	$ **(1,774)**	$ **2,455,414**	$ **(6,550)**	$ -	$ **(40,066,313)**

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Attachment B

Medi-Cal: Professional Fees				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2021 Input**	**Authorization**	**Appropriation**
Legal	General and Adversarial Legal Fees	1,200,000	X	X
Consulting	Internal Audit on Operations	300,000	X	X
Consulting	Rebasing, Network Support and Other Related Actuarial Consulting Services	250,000	X	X
Consulting	Government Affairs Contract and Management of State and Federal Lobbyists	240,000	X	X
Audit Fees	Medical Loss Ratio Audit	225,000	X	X
Professional Fees	Consultant to Assess CalOpima Professional Growth Strategic Plan including External Investigations, HR Consulting Services, Outsourcing Leaves of Absence Processing and Others	205,000	X	X
Audit Fees	Financial Audit Annual Contract	195,000	X	X
Consulting	Consulting Fees To Support Program Outreach and Social Media Efforts, Acquiring Data for Strategic Direction	174,000	X	X
Professional Fees	Employee Engagement and Feedback, Executive Recruiter Expenses, Compensation and Classification and Ad Hoc Consulting	165,500	X	X
Consulting	Health Insurance Portability and Accountability Act (HIPAA) Security Compliance, including Risk Management and Network Penetration	150,000	X	X
Consulting	Investment Advisory Annual Contract	90,000	X	X
Professional Fees	Core Systems Upgrade Consultation and Technical Training and Other Core Application Support	80,002	X	X
Professional Fees	Professional Fees for Other Post Employment Benefits (OPEB) and Various Accounting and Related Consulting Services	79,000	X	X
Consulting	Chronic Illness and Disability Payment System (CDPS) Renormalization and Coefficient Development	70,000	X	X
Consulting	Data Loss Prevention and Miscellaneous Consulting/Professional Services	62,000	X	X
Professional Fees	Professional Services Required for Corporate Applications and Systems	50,000	X	X
Consulting	Support for Implementation of Strategic Plan, Initiatives Aligned with Strategic Plan and Other Programs	50,000	X	X
Consulting	Consultant for Medi-Cal Mock Audit and Other Required Audits	45,000	X	X
Professional Fees	Professional Fees for Budget and Procurement Support	40,000	X	X
Consulting	Consultants to Assist in Program Readiness, Implementation of Homeless Health and Other Initiatives	36,000	X	X
Consulting	Space Planning Services	18,000	X	X
Consulting	Annual IBNR Certification Review	18,000	X	X
Consulting	Consultant to Support Improving Section 508 Accessibility Compliance of the Website for Use by People with Disabilities	6,000	X	X
Consulting	Required Annual A-133 Audit	4,300	X	X
Consulting	Consulting Fees to Assist in Developing a System to Support Behavioral Health Functions	0	X	X
Consulting	Consulting Fees to Assist in Improving Efficiencies in Implementing Programs, Business Initiatives and Compliance with Regulatory Requirements	0	X	X
	Total Professional Fees	**3,752,802**		

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Attachment B

Medi-Cal: Purchased Services				
Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Claims Review	Claims Prepayment Editing Services	2,020,000	X	X
Claims Review	Overpayment Identification Services	1,627,500	X	X
Claims Review	Coordination Of Benefits (COB) Project	1,450,000	X	X
Purchased Services	Pharmacy Benefits Management	1,254,000	X	X
EDI Claims Clearinghouse	Electronic Data Interchange Institutional Claims	1,089,000	X	X
Interpretive Services	Face to Face Interpreter Services	650,000	X	X
Purchased Services	Conversion of Temporary Assistance for Needy Families (TANF) to Supplemental Security Income (SSI)	620,000	X	X
Interpretive Services	Telephonic Interpreter Services	431,000	X	X
Bank Fees	Business Bank Fees	400,000	X	X
Claims Review	Long-Term Care Rate Adjustments	390,000	X	X
Purchased Services	Third Party Check Printing and Mailing Fees	384,000	X	X
Imaging Services	Claims Imaging and Indexing Services	351,000	X	X
Purchased Services	Disaster Recovery Technology Services	300,000	X	X
Advertising	Radio, Television, Print, Outdoor, Digital Advertising and Other Media to Promote and Support Enrollment and Participation	165,000	X	X
Advertising	Recruitment Advertisement and Sourcing	120,000	X	X
Purchased Services	Healthcare Productivity Automation Services	115,750	X	X
Broker Services	Insurance Broker Services	115,500	X	X
Purchased Services	Benefit Broker Services	115,000	X	X
Interpretive Services	Translation Services for Threshold Languages	99,000	X	X
Purchased Services	Service to Provide Security Protocol for Data Migration to Microsoft Cloud	80,000	X	X
Employee Benefits	Flexible Spending Accounts (FSA)/Consolidated Omnibus Budget Reconciliation Act (COBRA)	55,000	X	X
Purchased Services	Offsite Backup Tape Storage and Services	54,000	X	X
Purchased Services	Regulatory 508 Compliance Remediation Services for PDF Files to Make Them Accessible to People with Disabilities on the Website as Required by CMS, Department of Health Care Services (DHCS) and Section 508 Regulations	54,000	X	X
Purchased Services	Telework, Handling, and Deliveries	50,000	X	X
Purchased Services	Executive Coaching	50,000	X	X
Purchased Services	Retirement Funds Advisory	50,000	X	X
Purchased Services	Background Screening	38,000	X	X
Purchased Services	Imaging Services	36,480	X	X
Purchased Services	Closed Captioning of Board Meeting Videos and Other Website Videos for Section 508 Accessibility Compliance. Outside Evaluation of Website Section 508 Compliance and Recommendations	36,000	X	X
Purchased Services	Member Experience Survey and Workforce Enhancement	35,000	X	X
Purchased Services	TB Shots and Other General Purchased Services	32,004	X	X
Interpretive Services	Video Interpreting, Translation Audit Review, Annual Translation Skills Assessment, New Hire Bilingual Testing and In-Design License	30,000	X	X
Purchased Services	Employee Assistance Program	30,000	X	X

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Attachment B

	Medi-Cal: Purchased Services			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2021 Input**	**Authorization**	**Appropriation**
Purchased Services	Online Phishing Testing Service, Security Newsletter Subscription and Other Services	24,000	X	X
Purchased Services	Tax Form Processing Fees and Other General Purchased Services	22,200	X	X
Purchased Services	Employee Wellness and Ad Hoc Programs	17,100	X	X
Purchased Services	Salary Survey	16,400	X	X
Purchased Services	Destruction of Electronic Media	12,000	X	X
Purchased Services	Claims Pricing Automation Enhancements	11,250	X	X
Purchased Services	Photography Services and Stock Photograph Purchases for Use in Member, Provider Outreach and Other Community Oriented Materials	10,000	X	X
Purchased Services	Drug Screenings	10,000	X	X
License fees	Compensation System Subscription Fee	9,000	X	X
Purchased Services	Promotional Activity (October Cyber Security Awareness Month) Annually	5,000	X	X
Purchased Services	General Services for Customer Services, Operations Management, Executive Office, Audit & Oversight, and Other Various Departments	2,953	X	X
	Total Purchased Services	**12,467,137**		

Attachment B

Medi-Cal: Printing & Postage				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2021 Input**	**Authorization**	**Appropriation**
Printing	Print, Fulfillment and Postage for Regular Mailings of Daily/Monthly Packets	3,136,800	X	X
Printing	Print Fulfillment and Postage for Ad Hoc Member Notices Mailings	691,200	X	X
Postage	General Postage for Outgoing Mail	674,000	X	X
Printing	Print Fulfillment and Postage for Newsletters	612,000	X	X
Printing & Postage	Mail Services Charges, Courier/Delivery of Print Materials	50,700	X	X
Courier	Printing of the Annual Report to the Community, Holiday Cards, Provider Press Newsletter and CalOptima Quality Care Campaign Outreach Materials	46,000	X	X
Printing	Provider Relations Annual Mailing and Postage Required to Ensure Provider Training and Education Compliance	30,000	X	X
Printing	CalOptima Brochures, Infographic, CalOptima Programs and Services and CalOptima Posters for Community Outreach Events	20,000	X	X
Printing	Printing Services for Facilities Projects and Events, Safety and Security, Other CalOptima Departments' Printing Needs	20,000	X	X
Printing	Miscellaneous Member Materials, Printing Expenses and Supplies for Various Departments	17,202	X	X
Printing	Strategic Plan and Other Initiatives Reporting to Community	12,000	X	X
Printing	Annual Contract Renewal Letters to the Providers and Member Materials for New Programs and Initiatives	7,000	X	X
Printing & Postage	Letters to Providers to Obtain Clinical Records for Utilization Review, Letters to Members Regarding Behavioral Health Services	4,000	X	X
	Total Printing & Postage	**5,320,902**		

Attachment B

	Medi-Cal: Other Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2021 Input**	**Authorization**	**Appropriation**
Equipment	Telecommunications and Network Connectivity Expenses, Business Telephones and Accessories (Desk Phones, Headsets, Tablets and Accessories)	1,660,000	X	X
Maintenance	CalOptima Link Software Licenses, an Online System for Provider Networks to Submit and View Authorizations, Check Claim Status and Remittance Payment Advice and to Verify Member Eligibility for Point of Service and Care	1,584,000	X	X
Maintenance	Facets Core System (Enrollment, Claims, Authorizations and Other Modules) License Renewal and Maintenance	1,558,400	X	X
Maintenance	Operating Systems and Office Software Suite License Costs to Support Entire Organization	1,377,500	X	X
Insurance	Insurance Premiums - Errors and Omissions Professional Liability - General and Property Liabilities - Excess Liabilities - Commercial Auto - Directors and Officers (D&O) - Network/Privacy (Cyber), Crime, Employment Practices Liability (EPL) - Earthquake, Pollution and Umbrella - Wage and Hour Coverage	1,310,500	X	X
Maintenance	Corporate Software Maintenance (Provider Sanctioning and Analytics, Data Warehouse Cleansing, Analytics, Business Application Workflow, Website Content Management, Compliance and Other Corporate Applications)	1,302,700	X	X
Maintenance	Network Connectivity Maintenance and Support for CalOptima Sites (Network Monitoring Tools, Web Filters, All Main Distribution Frame and Intermediate Distribution Frame Batteries, Internet Optimizers, Routers, Wireless Application Protocol Devices, Other Tools)	1,209,000	X	X
Maintenance	Information Security Data Loss Prevention Solution Annual Maintenance	955,900	X	X
Maintenance	User Licenses for Claims Medicare Pricing Software	875,004	X	X
Maintenance	Server Connectivity Maintenance and Support for Server Equipment (Servers, Storage, Virtual Machine Licenses, Backup Software)	727,000	X	X
Professional Dues	Association Membership Dues (Provide Advocacy, Program Support, Technical Support Regarding State and Federal Regulatory Issues)	686,550	X	X
Equipment	Replacement Hardware for Operating System Upgrade, Desktop Software Licenses, and Other Minor Computer Equipment, Laptop and Desktop Replacements	605,000	X	X
Training & Seminar	Training & Seminar - Professional Development and Education - System and Software Update Training - Process Improvement Training - Financial and Reporting Software Upgrade and Training - Training Classes for Facility Management, Environmental and Safety Issues - Training Classes for Professional Certifications and Continuing Legal Education	504,965	X	X
Subscriptions	Cloud Government/Storage Subscription	500,000	X	X

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	Medi-Cal: Other Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2021 Input**	**Authorization**	**Appropriation**
Maintenance	Human Resources Corporate Application Software Maintenance (Training, Recruitment, Performance Evaluation, HR Benefits, Employee Time and Attendance and Payroll)	395,000	X	X
Maintenance	Application Software Maintenance - IT Development Tools (Data Modeling, Architecture, Technical L braries, Documentation, Technical Frameworks, Electronic Data Interchange, Software Development Testing)	382,600	X	X
Maintenance	Contract Management System	333,180	X	X
Subscriptions	Healthcare Information Research and Analysis, Information Systems Audit and Control, Association Subscription Renewal	324,310	X	X
Maintenance	Maintenance and Support Annual Renewal for the Telecommunications Network Systems	323,951	X	X
Maintenance	Provider and Physician Credentialing System Maintenance and License Renewal	308,270	X	X
Maintenance	Additional Software License and Upgrade Costs for Operating Systems and Office Software Suite	300,000	X	X
Maintenance	Finance Corporate Applications Software Maintenance (Accounting, Finance and Procurement Systems)	266,000	X	X
Office Supplies	Office Supplies (Paper, Toner, Batteries, Mouse Pads, Keyboards, Environmental Health and Safety, Disaster Recovery, Other Miscellaneous Items) for Company-Wide Usage	260,000	X	X
Equipment	Purchases and Installation of Office Furniture for Adds, Moves, Furniture, Fixture and Equipment, and Various Other Articles of Minor Equipment	240,000	X	X
Maintenance	24/7 Support to Assist CalOptima's Operating Systems and Office Software Suite Related Questions and Issues	200,000	X	X
Repair & Maintenance	Maintenance for Windows and Carpet Cleaning, Furniture Repair, Doors, Audio Visual Equipment, Plumbing and Other General Maintenance Needs	190,000	X	X
Maintenance	Maintenance and Support for the Production/Development of Citrix Operating System/Software Environments	165,000	X	X
Maintenance	Software to Generate and Interface with Facets Letters	150,000	X	X
Education	Tuition Reimbursement for Staff Development and Organizational Development Programs (CalOptima Special Speakers, Trainers, Computer Classes, Other Training Events)	150,000	X	X
Public Activities*	Sponsorship, Registration Fees and Other Related Costs for New and Anticipated Community Events and Health Fairs	120,000	X	X
Training	Board Member Stipends, Memberships, Conferences, Training and Travel	97,550	X	X
Office Supplies	Office Supplies for Various Departments' Needs for Everyday Operations	87,091	X	X
Professional Dues	Professional Dues and Member Fees for Various Professional Associations	80,665	X	X
Maintenance	Capital Project Related Maintenance	75,000	X	X
Maintenance	Database Administrator License Renewals, Maintenance and Support	68,000	X	X

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	Medi-Cal: Other Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2021 Input**	**Authorization**	**Appropriation**
Maintenance	Information Services Corporate Software Maintenance - Enterprise Help Desk Management Application	66,000	X	X
Travel	Travel - Conferences/Seminars and Meetings for Managers and Staff - State Meetings Related to Regulatory and Legislative Issues, Strategic Development - Association Meetings - Vendor Site Visits, Field Staff Visits - Mileage and Parking Reimbursement for Community Events and Presentations, Provider Offices and Member Enrollment	64,644	X	X
Maintenance	Subscription Renewal for Standard Medical Coding Schedules and Multiple User Licenses	59,100	X	X
Food Services	Employee Appreciation Events	48,500	X	X
Public Activities	Employee Engagement Events	46,600	X	X
Public Activities	Orange County Community Indicators Report, New and Expanded Strategic Planning Engagement and Rollout and Affiliation Fees	40,000	X	X
Maintenance	Maintenance and Support for Batch Scheduler System	35,000	X	X
Subscriptions	Subscription Fees for Various Licenses, Literature and Organizations	34,542	X	X
Maintenance	Maintenance and Support for Printers	30,000	X	X
Maintenance	Maintenance of Computer Software and Hardware	27,400	X	X
Maintenance	Annual Maintenance for MSSP Software License	25,000	X	X
Subscriptions	Subscriptions for Existing Software and Databases	23,292	X	X
Food Services	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences, Department Meetings and Other Events	21,468	X	X
Food Services	Food Services for Community Events and Supporting New Initiatives	15,000	X	X
Food Services	General Supplies for CalOptima Staff	15,000	X	X
Maintenance	Accounting Software Annual Maintenance	12,000	X	X
Software	Computer Software for Medical Coding and Design of Print Materials and Other Related Expenses	10,650	X	X
Public Activities	Supplies and Costs Associated with Various Outreach, Community Events, Sponsorships and Health Fairs	10,500	X	X
Telephone	Field Staff Phone Service and Other Telephone Expenses	10,300	X	X
Subscriptions	Subscription Fees for Electronic Surveys and Education Videos for Members	10,000	X	X
Food Services	Events and CCN Anniversary Event	9,000	X	X
Professional Dues	Medical Licenses and Required Certifications	8,400	X	X
Maintenance	Maintenance and Renewal for Procurement Software	8,000	X	X
Subscriptions	Subscription Fees for Both Clinical and Programmatic Support, and Normal Maintenance of Certification Licensure	7,200	X	X

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	Medi-Cal: Other Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2021 Input**	**Authorization**	**Appropriation**
Public Activities	Promotional and Outreach Activities to Help Support CalOptima Progams and Initiatives	6,000	X	X
Food Services	Food Services for Annual CalOptima Event to Promote Mental Health Awareness and Other Events	4,000	X	X
Food Services	Food Services for Advisory Committees, Existing and New Collaboratives, Stakeholder Engagement For New Initiatives	3,600	X	X
Food Services	Food Services for CalOptima Informational Series, Legislative Luncheon Events, Member and Provider Meetings/Conferences, Board Meetings and Other Events	3,500	X	X
Other Expenses	State Non-Reimbursable Funds for Services and Items for MSSP Clients	1,600	X	X
	Total Other Operating Expenses	**20,029,432**		

* All Community Events and Activities Involving Financial Support from CalOptima of Over $1,000 Requires Prior Explicit Board Approval

Attachment B

OneCare Connect: Professional Fees

Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Consulting	Centers for Medicare & Medicaid Services (CMS) Program Audit for Onecare and OneCare Connect	300,000	X	X
Consulting	Annual Compliance Program Effectiveness (CPE) Audit	90,000	X	X
Actuary	Percentage of Premium Sufficiency, Fully-Integrated Special Needs Plans (FIDE SNP) Consideration and Other Related Actuarial Consulting Services	64,000	X	X
Consulting	CMS Data Validation Audit	27,000	X	X
	Total Professional Fees	**481,000**		

OneCare Connect: Purchased Services

Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Purchased Services	Pharmacy Benefits Management	876,000	X	X
Advertising	Advertising and Media Buys (Newspapers, Magazines, Radio, Bus Shelter, Other Media)	130,000	X	X
Interpreter Services	Language Interpretation and Translation of Member Materials	100,000	X	X
Data Transmission	Claims Processing through Automation Data Flow	42,000	X	X
Purchased Services	Compliance and Ethics Hotline	40,000	X	X
Purchased Services	Exclusion Monitoring Software	26,000	X	X
Data Transmission	Data Submission To and From CMS for Enrollment and Regulatory Reporting and Hierarchical Condition Category (HCC) Scores Analytics	24,000	X	X
Purchased Services	Purchased Services Need for Customer Service and Financial Analysis	2,950	X	X
	Total Purchased Services	**1,240,950**		

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OneCare Connect: Printing & Postage

Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Printing & Postage	Maintenance of Enrolled Members (Printing, Fulfillment, Postage), Member Routine Annual and Quarterly Mailings, Other Related Printing and Postage Expenses	598,000	X	X
Member Communications	Marketing Materials, Including Sales Brochures, Posters, Handouts and Other Member and Provider Oriented Materials and Postage	556,500	X	X
Printing & Postage	Printing of Enrollment Materials and Other Related Printing Expenses	85,000	X	X
Member Communications	Member and Provider Materials, Compliance Week Printing and Fulfillment and Other Printing Fees for Various Departments	38,720	X	X
	Total Printing & Postage	**1,278,220**		

OneCare Connect: Other Operating Expenses

Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Public Activities	Fees for Registration, Sponsorships, Promotional Items for Community Events, Resource Fairs, Health Fairs and Other Events; Costs Tied to Supplies to Prepare and Participate	96,500	X	X
Public Activities	Marketing and Outreach Activities and Promotional Items for Various Events	43,500	X	X
Travel	Travel Expenses for Visits to Provider Offices, Presentations, Health Fairs, Community Events, Annual Audits and Conferences	17,200	X	X
Subscriptions	Subscriptions and Professional Dues	15,215	X	X
Training & Seminars	Training and Seminars for Professional Development and Education	9,760	X	X
Food Services	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences, Community Events, Compliance Week, and Department Training and Meeting	8,200	X	X
Office Supplies	Office Supplies Needed for Everyday Department Operations and Compliance Week Supplies	3,900	X	X
	Total Other Operating Expenses	**194,275**		

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OneCare: Professional Fees				
Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Consulting	Annual Contract Bid for OneCare	192,000	X	X
	Total Professional Fees	**192,000**		

OneCare: Purchased Services				
Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Purchased Services	Pharmacy Benefits Management	90,000	X	X
Interpreter Services	Language Interpretation and Translation of Member Materials	27,000	X	X
	Total Purchased Services	**117,000**		

OneCare: Printing & Postage				
Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Member Communications	Maintenance of Enrolled Members (Printing, Fulfillment, Postage)	82,000	X	X
Member Communications	Member Enrollment and Other Required Materials	15,000	X	X
	Total Printing & Postage	**97,000**		

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OneCare: Other Operating Expenses

Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Travel	Travel Expenses for Conferences/Seminars and Meetings	3,000	X	X
Professional Dues	Professional Certifications	3,000	X	X
Food Services	Food Services for Department Training and Other Events	350	X	X
Office Supplies	Office Supplies Needed for Daily Operations	100	X	X
	Total Other Operating Expenses	**6,450**		

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PACE: Professional Fees

Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Professional Fees	Part D Actuarial Services and Other Financial Consulting Fees	2,000	X	X
	Total Professional Fees	**2,000**		

PACE: Purchased Services

Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Purchased Services	Advertising (Radio, Television, Print, Outdoor, Digital and Other Mediums) to Promote and Support Enrollment and Participation	210,000	X	X
Purchased Services	Health Outcomes and Satisfaction Surveys, Encounter Data File Formatting, Sterilization of Medical Equipment, Provider Communication, Appointment Services and Other Related Expenses	3,324	X	X
	Total Purchased Services	**213,324**		

PACE: Printing & Postage

Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Printing & Postage	Participant Newsletter, Typesetting for Translated Materials, Printing, Fulfillment and Postage Costs for Direct Mail Campaign, Marketing Materials and Other Printing Expenses	140,400	X	X
	Total Printing & Postage	**140,400**		

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PACE: Other Operating Expenses

Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Repairs & Maintenance	Software License and Support, Repairs and Maintenance of Minor Equipment, Building and Unforeseen Incidentals and Building Security Services	19,920	X	X
Public Activities	Outreach Events and Promotional Marketing Items to Help Elevate PACE Center and Support Program Enrollment and Expansion	7,868	X	X
Food Services	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences and Trainings	6,100	X	X
Utilities	Electricity, Gas, Water and Other Related Expenses	3,120	X	X
Insurance	General Liability, Property, Earthquake and Other Insurance Fees	2,080	X	X
Property Tax	Property Tax Assessment	932	X	X
Training	Staff Development Training (Registration Fees, Travel, Accommodations, Incidentals)	800	X	X
Minor Equipment & Supplies	Minor Equipment and Supplies (Kitchen, Rehab, Social Day, Staff Break Room, Clinic Small Equipment)	560	X	X
Travel	Staff Travel and Mileage for Home Visits, Marketing, Conferences and Enrollment	492	X	X
Supplies	Office Supplies for Staff	412	X	X
Subscriptions	Subscriptions, Membership, Registration for Dietetic and Other Discipline Specific Memberships	386	X	X
	Total Other Operating Expenses	**42,670**		

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MSSP: Professional Fees				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2021 Input**	**Authorization**	**Appropriation**
Consulting	A-133 Annual Audit Requirement	4,298	X	X
	Total Professional Fees	**4,298**		

MSSP: Purchased Services				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2021 Input**	**Authorization**	**Appropriation**
Interpreter Services	Language Interpretation and Translation of Member Materials	248	X	X
	Total Purchased Services	**248**		

MSSP: Printing & Postage				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2021 Input**	**Authorization**	**Appropriation**
Member Communications	Return Envelopes & Brochures for Members	248	X	X
	Total Printing & Postage	**248**		

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MSSP: Other Operating Expenses

Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Maintenance	Information Management Software for Long Term Care	24,998	X	X
Telephone	Cell Phones and Data Plans for Field Staff and Management Team who Complete Onsite Home Assessments	9,998	X	X
Travel	Regular Home Visits with Members for Field Staff	5,648	X	X
Professional Dues	Professional Certifications	3,150	X	X
Other Expenses	Member Services Provided by Care Managers	1,598	X	X
Training & Seminar	Professional Development and Education	1,500	X	X
Office Supplies	Routine Office Supplies for Field and Office Staff	900	X	X
Food Services	Food Services for Department Training and Other Events	98	X	X
	Total Other Operating Expenses	**47,890**		

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Facilities: Purchased Services				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2021 Input**	**Authorization**	**Appropriation**
Fire/Life Safety Security	Security Contract	381,110	X	X
Building Administration	Property Management, Administration Fee and Other Related Expenses	278,890	X	X
	Total Purchased Services	**660,000**		

Facilities: Printing & Postage				
Specific Type	**Objective of the Item Proposed**	**Budget FY 2021 Input**	**Authorization**	**Appropriation**
Postage	Postage and Courier	2,000	X	X
	Total Printing & Postage	**2,000**		

	Facilities: Other Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2021 Input	Authorization	Appropriation
Utilities	Electricity	426,722	X	X
Janitorial	Janitorial Night Contract	353,296	X	X
Repairs & Maintenance	Engineering Contract	222,099	X	X
Insurance	Property, Liability and Earthquake Insurance	222,000	X	X
Janitorial	Janitorial Day Contract	130,091	X	X
Repairs & Maintenance	Other Repair and Maintenance (Signage, Steam Cleaning, Roof, Locksmith, Pest Control Contract, Other Maintenance)	94,640	X	X
Repairs & Maintenance	HVAC Miscellaneous	92,054	X	X
Janitorial	Janitorial Supplies	90,000	X	X
Repairs & Maintenance	Plumbing	56,940	X	X
Repairs & Maintenance	Electrical Repairs and Supplies	45,250	X	X
Landscape	Exterior Landscape Contract	45,000	X	X
Repairs & Maintenance	Water Treatment	33,920	X	X
Repairs & Maintenance	Windows	32,172	X	X
Landscape	Landscape Extras	30,400	X	X
Fire/Life Safety Security	Other Fire/Life Safety Expenses (Phone, Emergency Generator, Other Expenses)	30,000	X	X
Repairs & Maintenance	Elevator Maintenance Contract	27,600	X	X
Repairs & Maintenance	HVAC Maintenance Contract	25,078	X	X
Fire/Life Safety Security	Security Equipment and Maintenance	22,780	X	X
Repairs & Maintenance	Walls/Ceilings/Floors/Sidewalks/Railings	21,800	X	X
Property Tax	Property Tax Assessments	21,000	X	X
Utilities	Water - Building	18,339	X	X
Building Expenses	Various Building Expenses (Trash, Water for Irrigation, Interior Plants)	16,003	X	X
Utilities	Gas	11,816	X	X
Parking Lot Maintenance	Parking Lot Maintenance	10,200	X	X
Repairs & Maintenance	Door Maintenance and Repair	8,800	X	X
Repairs & Maintenance	Painting	6,000	X	X
	Total Other Operating Expenses	**2,094,000**		

CalOptima
A Public Agency
Better. Together.

Fiscal Year 2020-21
Proposed Operating and Capital Budget

Board of Directors Meeting
June 4, 2020

Nancy Huang, Chief Financial Officer

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Overview

- Update from Finance and Audit Committee (FAC)
- State May Revise Update
  - State budget proposal highlights
  - Estimated impact to Medi-Cal managed care plans
- FY 2020-21 Consolidated Budget Overview
  - Program changes and operational updates
  - Updated budget and comparison reports
- Operating Budget Details by Line of Business
- Capital Budget

Update from Finance and Audit Committee

- 5/21/20 meeting: Did not take action on the proposed FY 2020-21 Operating Budget

- Instructed staff to re-evaluate the following items:
  - Remove or reduce certain salary-related expenses
  - Increase the vacancy factor
  - Review non-salary items to identify potential savings

- Staff will bring a revised FY 2020-21 Operating Budget to the June 4, 2020, Board of Directors meeting

FY 2020-21 Operating Budget

State May Revise Update

May Revise Highlights

- 5/14/20: Governor released May Revise
  - General Fund Budget: $133.9 billion
  - Total reserves: $8.35 billion
  - $54.3 billion budget deficit for FY 2019-20 and FY 2020-21
  - Assumes Medi-Cal caseload will hit 14.5 million by July 2020
    - 2 million higher than levels without COVID-19

- Mid-May to Mid-June: State Senate and Assembly will hold budget hearings, meet in conference committee to resolve any differences and negotiate with Administration

- 6/15/20: Deadline for State Legislature to enact a balanced budget

May Revise Proposals

- $54.3 billion budget gap for FY 2019-20 and FY 2020-21
  - Gap addressed through a combination of cost savings proposals
- New Medi-Cal budget proposals in May Revise
  - 1.5% rate reduction from 7/1/19 – 12/31/20 (i.e., Bridge Period)
  - Capitation rate adjustments effective rate year beginning 1/1/21
    - Projected 3% decrease to Medi-Cal base rates for acuity, efficiency and cost containment adjustments
- Cancelled expansions or other reductions from January Budget
  - Delayed implementation of CalAIM
  - Cancelled Medi-Cal eligibility expansion for:
    - Undocumented adults 65 and older; and
    - SPDs with incomes between 123% and 138% FPL

May Revise Proposals (cont.)

- Trigger cuts, if federal funding does not materialize
  - Reduce adult dental benefits to partial restoration levels in 2014
  - Eliminate Medi-Cal optional benefits
  - Eliminate CBAS effective 1/1/21
  - Eliminate MSSP effective 7/1/20
  - Shift $1.2 billion in Proposition 56 funding to pay for Medi-Cal caseload growth effective 7/1/20

May Revise Impact on Medi-Cal Budget

	Balanced Medi-Cal Budget Before May Revise		Medi-Cal Budget After May Revise		
Categories	**Original Trends**	**Revenue Change**	**New Trends**	**Revenue Change**	**Differences**
Classic	0%	$0M	-1.5% Jul 2020-Jun 2021 Add'l: -3% Jan-Jun 2021	-$43M	**-$43M**
Expansion	-5% Jan-Jun 2021	-$25M	-1.5% Jul 2020-Jun 2021 Add'l: -5% Jan-Jun 2021	-$42M	**-$17M**
WCM	+9% Jan-Jun 2021	+$9M	-1.5% Jul-Jun 2021 Add'l: +5.7% Jan-Jun 2021	+$2M	**-$7M**
Total Revenue Change		-$16M		-$83M	**-$67M**
Total Revenue	$3,252,680,471		$3,185,809,324		**-$66,871,147**
Case Mgmt & Other Medical	$96,474,372		$91,753,453		**-$4,720,919**
G&A Expenses	$140,862,456		$127,905,486		**-$12,956,970**
Operating Income / (Loss)	$0M		-$46,832,859		**-$46,832,859**

CalOptima Budget Outlook

- May Revise reductions deeper than originally anticipated
  - Uncertainty remains on actual size of next year's revenue cuts
  - Potential impact of trigger cuts significant to members, providers and Orange County safety net system
- Given current COVID-19 environment and strain on provider community, proposed budget includes:
  - Moving forward with planned provider rate adjustments
  - Absorbing additional revenue reduction from May Revise
  - Proposing leaner internal operations
- Uphold CalOptima's mission: Ensure member access to quality care

FY 2020-21 Consolidated Budget Overview

FY 2020-21 Budget Overview

- Program Updates
  - January 2021: Pharmacy benefit carve-out
  - January 2021: MSSP carve-out of Medi-Cal
    - MSSP elimination part of the May Revise proposed trigger cuts

- Planned Rate Adjustments
  - July 2020: Medi-Cal Classic capitation adjustments resulting from rebasing
  - July 2020: Medi-Cal Expansion capitation adjustments
  - July 2020: CDPS risk adjustment for Medi-Cal Expansion
  - January 2021: Percent of premium adjustments to OneCare Connect hospital capitation

FY 2020-21 Budget Overview (cont.)

- Enrollment trends
  - Significant increase in Medi-Cal TANF (Adult and Child) and Expansion members due to COVID-19
  - Slight decrease in OneCare Connect and OneCare
  - Moderate increase in PACE
- Revenue assumptions (CY21 vs. CY20)
  - Medi-Cal Classic: Decrease of 3%
  - Medi-Cal Expansion: Decrease of 5% or approximately $25 million
  - Medi-Cal WCM: Increase of 5.7% or approximately $5 million
  - Medicare Revenue (OneCare Connect, OneCare, PACE): Slight increase, in aggregate

FY 2020-21 Budget Overview (cont.)

- Medical Costs
  - Hospital and Professional capitation
    - Medi-Cal Classic: Align capitation with risk
      - Exclude CCS from Medi-Cal Classic experience
    - Expansion: Continued reduction to capitation
      - Right size to levels supported by membership and utilization data
  - Fee-For-Service cost and utilization trends
    - Continued increase in non-medical transportation utilization
    - Increasing pharmacy unit cost trends
    - Trend adjustments for newly eligible Medi-Cal members
  - Pay for Value (P4V) program funding increase
  - SNF and ancillary providers rate increase

G&A Budget Reductions/Removals After FAC

Expense Categories	Total Amount	Description
Internal Medical Mgmt Expenses	-$4.1M	Compensation Study
	-$2.3M	Vacancy Factor (5% to 10%)
	-$0.4M	Multiple areas
Total Internal Medical Mgmt Expenses:	**-$6.8M**	
Salaries, Wages & Employee Benefits	-$7.0M	Compensation Study
	-$3.3M	Vacancy Factor (5% to 10%)
	-$2.2M	Existing/vacant positions (Reduced total by 20 FTEs)
	-$0.3M	Upgrades and retention bonus
Other Non-salary	-$1.4M	Multiple areas
Occupancy/Indirect Cost Allocation	-$0.7M	Lease funding for space capacity need
Total G&A Expenses:	**-$14.9M**	
Total Reduction:	**-$21.7M**	All LOBs

G&A Budget: FY 2020-21 Base Analysis

- Using FY 2019-20 G&A forecast as base, applies additional adjustments
  - Seasonality adjustment of +4%
  - Enrollment adjustment of +8%

- Adjusted G&A base $151.4M for FY2020-21

	Total G&A	ALR
FY 2019-20 Forecast	$134.4M	3.7%
Seasonality Adjustment (4%)	+$5.6M	
Enrollment Adjustment (8%)	+$11.4M	
FY 2020-21 G&A Base	$151.4M	4.3%
FY 2020-21 G&A Base vs. FY 2019-20 Forecast	*$17.0M*	*0.6%*

Updated FY 2020-21 Consolidated Budget After Reductions/Removals

	FY 2020-21 Budget Proposed to FAC	Add'l Reductions	FY 2020-21 Budget
Revenues	**$3,555,013,609**	**N/A**	**$3,555,013,609**
Case Mgmt & Other Medical	**$131,919,279**	**($6,775,646)**	**$125,143,633**
Salaries, Wages & Benefits	**$108,502,832**	**($12,805,537)**	**$95,697,295**
Non-Salaries	**$57,804,002**	**($2,075,023)**	**$55,728,979**
Professional Fees	$4,687,662	($255,562)	$4,432,100
Purchased Services	$15,305,052	($606,393)	$14,698,659
Printing & Postage	$7,173,171	(334,401)	$6,838,770
Depreciation & Amortization	$7,653,840	$0	$7,653,840
Other Operating Exp/Indirect Cost Allocation, Occupancy	$22,984,277	($878,667)	$22,105,610
Total G&A	**$166,306,834**	**($14,880,560)**	**$151,426,274**
ALR	**4.7%**	**-0.4%**	**4.3%**

Consolidated Income Statement
FY 2019-20 Budget vs FY 2020-21 Budget

	FY 2019-20 Budget**	FY 2020-21 Budget	FY 2020-21 Budget vs. FY 2019-20 Budget
Average Monthly Enrollment	743,485	800,302	56,817
Revenue	$3,565,765,952	$3,555,013,609	($10,752,343)
Medical Costs	$3,399,171,169	$3,458,653,648	$59,482,479
Administrative Expenses	$157,173,246	$151,426,274	($5,746,972)
Operating Income/Loss	**$9,421,537**	**($55,066,313)**	**($64,487,850)**
Investments, Net	$15,000,000	$15,000,000	$0
Change in Net Assets*	**$24,421,537**	**($40,066,313)**	**($64,487,850)**
MLR	95.3%	97.3%	2.0%
ALR	4.4%	4.3%	-0.1%

*Change in net assets excludes investment and other income
** Includes Board actions on budget adjustments as of March 2020

FY 2019-20 Forecast vs. FY 2020-21 Budget

	FY 2019-20 Forecast*	FY 2020-21 Budget	FY 2020-21 Budget vs. FY 2019-20 Forecast
Revenues	**$3,642,286,855**	**$3,555,013,609**	**$(87,273,246)**
Salaries, Wages & Benefits	**$88,405,275**	**$95,697,295**	**$7,292,020**
Non-Salaries	**$45,987,131**	**$55,728,979**	**$9,741,848**
Professional Fees	$3,212,922	$4,432,100	$1,219,178
Purchased Services	$12,272,285	$14,698,659	$2,426,374
Printing & Postage	$4,964,763	$6,838,770	$1,874,007
Depreciation & Amortization	$6,007,358	$7,653,840	$1,646,482
Other Operating Exp/Indirect Cost Allocation, Occupancy	$19,529,803	$22,105,610	$2,575,807
Total G&A	**$134,392,406**	**$151,426,274**	**$17,033,868**
ALR	**3.7%**	**4.3%**	**0.6%**

- Forecasted as of March 2020; Revenue excludes directed payments
- FY 2019-20 forecasted figures do not include unfilled open positions

G&A Budget: Bridge for FY 2019-20 Forecast vs FY 2020-21 Budget

G&A Expense	Bridge	Description
Salaries, Wages & Employee Benefits	$7.3M	Existing/vacant positions (80 FTEs) and new positions (16 FTEs) [$4.8M], Increase in Vacancy Factor from 5% to 10% [-$3.3M], Merit increase (3%) [$2.4M], Overtime [$2.4M], Upgrades and retention bonus [$1.0M]
Professional Fees	$1.2M	Internal audit, legal fees, consulting for new initiatives and software applications, financial and other required audits
Purchased Services	$2.4M	Increase in EDI clearinghouse, forensic review, and prepayment edit, member interpretation and translation, advertising and regulatory compliance services
Printing & Postage	$1.9M	Increase in mailing and processing of member packages and notices, postage costs, direct mail campaign, and support in marketing and outreach materials for members and providers
Other Operating Expenses	$2.5M	Increase in software licenses and maintenance agreements, insurance policy increase, building maintenance and supplies, staff education and development
Depreciation & Amortization	$1.7M	FY 2019-20 and FY 2020-21 capital items placed in service
Total:	**$17.0M**	

CalOptima Consolidated Income Statement: Attachment A

Attachment A

CalOptima Fiscal Year 2020-21 Budget
By Line of Business

	Medi-Cal (Classic)	Medi-Cal (Expansion)	Medi-Cal (WCM)	Total	OCC	OneCare	PACE	MSSP	Facilities	Consolidated
Member Months	6,258,987	3,011,857	143,178	9,414,022	167,856	16,536	5,211	2,730	-	**9,603,625**
Avg Members	521,582	250,988	11,931	784,502	13,988	1,378	434	455	-	**800,302**
Revenues										
Capitation revenue	$ 1,706,161,985	$ 1,228,272,960	$ 251,374,380	$ 3,185,809,324	$ 306,323,384	$ 19,472,782	$ 42,189,583	$ 1,218,536	$ -	**$ 3,555,013,609**
Total	$ 1,706,161,985	$ 1,228,272,960	$ 251,374,380	$ 3,185,809,324	$ 306,323,384	$ 19,472,782	$ 42,189,583	$ 1,218,536	$ -	**$ 3,555,013,609**
Medical Costs										
Provider capitation	$ 525,065,237	$ 544,737,283	$ 101,059,284	$ 1,170,861,804	$ 132,514,946	$ 5,220,667	$ -	$ -	$ -	**$ 1,308,597,418**
Claims Payments	$ 557,986,264	$ 422,990,239	$ 97,076,012	$ 1,078,052,514	$ 59,102,790	$ 6,184,669	$ 18,272,209	$ -	$ -	**$ 1,161,612,182**
LTC/Skilled Nursing Facilities	$ 432,568,164	$ 37,233,712	$ 13,282,179	$ 483,084,055	$ 18,145,318	$ -	$ 826,406	$ 158,410	$ -	**$ 502,214,188**
Prescription Drugs	$ 103,242,805	$ 143,275,777	$ 34,466,289	$ 280,984,871	$ 70,776,758	$ 5,897,339	$ 3,427,259	$ -	$ -	**$ 361,086,227**
Case Mgmt & Oth Medical	$ 51,663,768	$ 35,630,054	$ 4,459,631	$ 91,753,453	$ 17,022,816	$ 525,047	$ 15,205,649	$ 636,667	$ -	**$ 125,143,633**
Total	$ 1,670,526,238	$ 1,183,867,064	$ 250,343,395	$ 3,104,736,697	$ 297,562,629	$ 17,827,723	$ 37,731,523	$ 795,076	$ -	**$ 3,458,653,648**
MLR	*97.9%*	*96.4%*	*99.6%*	*97.5%*	*97.1%*	*91.6%*	*89.4%*	*65.2%*		*97.3%*
Gross Margin	$ 35,635,746	$ 44,405,895	$ 1,030,985	$ 81,072,627	$ 8,760,755	$ 1,645,059	$ 4,458,061	$ 423,459	$ -	**$ 96,359,961**
Administrative Expenses										
Salaries, Wages, & Employee Benefits				$ 83,409,902	$ 9,604,947	$ 812,160	$ 1,524,159	$ 346,127	$ -	**$ 95,697,295**
Professional Fees				$ 3,752,802	$ 481,000	$ 192,000	$ 2,000	$ 4,298	$ -	**$ 4,432,100**
Purchased services				$ 12,467,137	$ 1,240,950	$ 117,000	$ 213,324	$ 248	$ 660,000	**$ 14,698,659**
Printing & Postage				$ 5,320,902	$ 1,278,220	$ 97,000	$ 140,400	$ 248	$ 2,000	**$ 6,838,770**
Depreciation & Amortization				$ 5,502,000	$ -	$ -	$ 24,840	$ -	$ 2,127,000	**$ 7,653,840**
Other Operating Expenses				$ 20,029,432	$ 194,275	$ 6,450	$ 42,670	$ 47,890	$ 2,094,000	**$ 22,414,717**
Indirect Cost Allocation, Occupancy Expense				$ (2,576,689)	$ 6,641,906	$ 422,224	$ 55,254	$ 31,198	$ (4,883,000)	**$ (309,107)**
Total				$ 127,905,486	$ 19,441,298	$ 1,646,834	$ 2,002,647	$ 430,009	$ -	**$ 151,426,274**
ALR				*4.0%*	*6.3%*	*8.5%*	*4.7%*	*35.3%*		*4.3%*
Operating Income/(Loss)				$ (46,832,859)	$ (10,680,544)	$ (1,774)	$ 2,455,414	$ (6,550)	$ -	**$ (55,066,313)**
Investment Income										$ 15,000,000
MCO Tax Revenue				$ 182,255,794						$ 182,255,794
MCO Tax Expense				$ (182,255,794)						$ (182,255,794)
CHANGE IN NET ASSETS				**$ (46,832,859)**	**$ (10,680,544)**	**$ (1,774)**	**$ 2,455,414**	**$ (6,550)**	**$ -**	**$ (40,066,313)**

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CalOptima A Public Agency Better. Together.

FY 2020-21 Operating Budget

Budgets by Line of Business

Medi-Cal Program

Start Date	October 1995
Program Type	California's Medicaid Program
Contractor/ Regulator	California Department of Health Care Services (DHCS)
Eligibility	• Child and family • Senior • Persons with disabilities • Low-income (includes Medi-Cal Expansion)
Services	• Comprehensive health • Prescriptions • Vision • Mental Health • MLTSS • (Dental provided by DHCS)

Medi-Cal Budget

	FY 2018-19 Actual	FY 2019-20 Forecast*	FY 2020-21 Budget
Average Monthly Enrollment	751,409	721,719	784,502
Revenue	$3,134,181,617	$3,289,166,019	$3,185,809,324
Medical Costs	$2,881,181,629	$3,144,826,354	$3,104,736,697
Administrative Expenses	$106,944,388	$111,931,109	$127,905,486
Operating Income/Loss**	**$146,155,600**	**$32,408,556**	**($46,832,859)**
Medical Loss Ratio	92.0%	95.6%	97.5%
Administrative Loss Ratio	3.4%	3.4%	4.0%

* Forecasted as of March 2020; Revenue excludes directed payments
** Change in net assets excludes net investment and other income
Includes MSSP from July to December 2020

Medi-Cal Revenue

- Medi-Cal Rate Assumptions

	Medi-Cal Classic	Medi-Cal Expansion	Medi-Cal WCM
Capitation rates	• Draft 18-month bridge period rates for 7/1/20 – 12/31/20 with incorporated 1.5% reduction • Draft Calendar Year (CY) 2021 rates expected Oct 2020		
	• Additional 3% reduction (total of -4.5%)	• Additional 5% reduction (total of -6.5%)	• Assumes 5.7% increase • Includes CCS and non-CCS services
BHT/ Hepatitis C Rates	FY 2019-20 rates		
CCI Rates	Draft CY 2019 rates for duals • Reweighted for projected cohort mix • Reduced by 1.5% July 2020 and additional 3% January 2021		NA

Medical Costs: Provider Rate Updates for Medi-Cal Classic

Medical Cost	Unit Cost Change	Detail
Provider Capitation	Decrease (-2.0%)	• TANF/SPD categories of aid: -12.8% Child and +7.2% Non-Child
Skilled Nursing Facility	Increase	• Includes +20% unit cost trend increase approved in the FY 2019-20 Operating Budget
Ancillary Provider Rate	Increase	• Mental health (Non-ABA): +15% unit cost increase for fee schedule change • Obstetrics: +13% increase
Pay for Value (P4V)	Increase	• From $2 PMPM maximum to $5 PMPM maximum

Medi-Cal Classic Rebasing Results

- Proposed capitation rates includes:
  - Budget neutrality adjustment
  - Additional trend across all COA / Risk
  - Potential completion of encounters
- Though WCM has been separately reimbursable since July 1, 2019, the current Medi-Cal Classic capitation rates include the higher experience
  - Health Networks have benefited from higher revenue for the past 12 months
- CalOptima has accounted for all unit cost increases that were implemented in the current fiscal year and proposed in upcoming budget

Medi-Cal Classic: Proposed Capitation Change

- Fiscal impact of rate reduction

Cost Type	% Change	$ Change	Impacted Entities
Professional Capitation	-0.5%	-$1M	Health Networks
Hospital Capitation	-3.9%	-$7M	Capitated Hospitals/ HMO Networks
Shared Risk Pool	Results from decrease to Hospital Capitation	-$0M	SRG Health Networks
Total	**-2.0%**	**-$8M**	

Medical Costs: Provider Rate Updates for Medi-Cal Expansion

Medical Cost	Unit Cost Change	Detail
Provider Capitation	Decrease (-10.6%)	• Professional: -7% • Hospital: -14%
Skilled Nursing Facility	Increase	• Includes +20% unit cost trend increase approved in the FY 2019-20 Operating Budget
Ancillary Provider Rate	Increase	• Mental health (Non-ABA): +15% unit cost increase for fee schedule change • Obstetrics: +13% increase
Pay for Value (P4V)	Increase	• From $2 PMPM maximum to $5 PMPM maximum

Medi-Cal Expansion: Capitation History

- Expansion health network capitation rates
  - Professional rates originally derived from a 50/50 blend of Disabled and Adult TANF populations
  - Hospital rates based on 100% of the Disabled population
  - Expectation of high risk for Expansion population when program began
  - Incentive to develop sufficient provider networks
- Expansion Capitation Rates

Service Type	Jan 2014	Sept 2014	Sept 2015	July 2016	July 2017	July 2019	*Proposed July 2020
Professional Capitation	$147.97	$199.91	$170.17	$144.64	$144.64	$133.07	$123.76
Hospital Capitation	$267.66	$361.61	$307.81	$261.64	$185.76	$146.75	$126.21
Total Capitation	**$415.63**	**$561.52**	**$477.98**	**$406.28**	**$330.41**	**$279.82**	**$249.96**
% Change	*+20%*	*+35.1%*	*-15.0%*	*-15.0%*	*-18.7%*	*-15.31%*	*-10.67%*

* Figures may not add due to rounding

Medi-Cal Expansion: Proposed Capitation Change

- Proposed Expansion rate change

Service Type	July 2019	Proposed (FY 20-21)	PMPM Change	% Change
Professional Capitation	$133.07	$123.76	-$9.31	-7.0%
Hospital Capitation	$146.75	$126.21	-$20.54	-14.0%
Total Capitation	**$279.82**	**$249.96**	**-$29.86**	**-10.7%**

- Proposed Expansion rate comparison to Adult TANF Classic

Service Type	Adult TANF Classic (FY 19-20)	Proposed (FY 20-21)	PMPM Difference	% Over Adult TANF Classic
Professional Capitation	$86.67	$123.76	$37.09	42.8%
Hospital Capitation	$65.17	$126.21	$61.04	93.7%
Total Capitation	**$151.84**	**$249.96**	**$98.12**	**64.6%**

* Figures may not add due to rounding

FFS Comparison

- Current FFS Comparison - % Medi-Cal Equivalent

Service Type	Classic	Expansion	% Over Classic
Professional PCP	129%	129%	0.0%
Professional Specialist	133%	156%	17.3%
Hospital Inpatient	108%	117.3%	8.6%
Hospital Outpatient	133%	133%	0.0%

Medi-Cal Expansion: Proposed Capitation Change

- Fiscal impact of rate reduction

Cost Type	% Change	$ Change	Impacted Entities
Professional Capitation	-7.0%	-$21M	Health Networks
Hospital Capitation	-14.0%	-$25M	Capitated Hospitals/ HMO Networks
Shared Risk Pool	Results from decrease to Hospital Capitation	-$5M	SRG Health Networks
Total	**-10.6%**	**-$50M**	

* Figures may not add due to rounding

Medical Costs: Medi-Cal WCM

- Continued to use draft rates as a proxy for actual experience
- Staff will analyze experience data as it becomes available
- Provides capitation with a risk corridor to Health Networks
- Higher than expected medical costs in Facilities, Long Term Care, Pharmacy services

Category	Jul-Dec 2020	Jan-Jun 2021	Total
Total Revenue	**$141,887,812**	**$109,486,568**	**$251,374,380**
Provider Capitation	$51,631,747	$49,427,537	$101,059,284
Medical Claims Cost	$48,010,557	$49,065,455	$97,076,012
Prescription Drugs	$34,466,289	$0	$34,466,289
Long Term Care	$6,446,537	$6,835,642	$13,282,179
Medical Management & Other	$2,288,050	$2,171,581	$4,459,631
Total Medical Costs	**$142,843,180**	**$107,500,215**	**$250,343,395**
MLR	**100.7%**	**98.2%**	**99.6%**

* Figures may not add due to rounding

OneCare Connect Program

Start Date	July 2015
Program Type	Medicare and Medicaid Duals Demonstration
Contractor/ Regulator	CMS and DHCS
Eligibility	Medi-Cal member who also has Medicare (i.e., dual eligible)
Services	• Comprehensive health • Prescriptions • Vision • MLTSS • Assessment • Care planning • Care coordination • Supplemental benefits

OneCare Connect Budget

	FY 2018-19 Actual	FY 2019-20 Forecast*	FY 2020-21 Budget
Average Monthly Enrollment	14,398	14,145	13,988
Revenue	$292,428,410	$296,342,072	$306,323,384
Medical Costs	$293,947,462	$286,650,446	$297,562,629
Administrative Expenses	$19,863,775	$18,706,540	$19,441,298
Operating Income/Loss	**($21,382,827)**	**($9,014,914)**	**($10,680,544)**
Medical Loss Ratio	100.5%	96.7%	97.1%
Administrative Loss Ratio	6.8%	6.3%	6.3%

* Forecasted as of March 2020

OneCare Connect Revenue

- OneCare Connect rate assumptions
  - Applies Year 3+ savings targets of 5.5%, quality withhold of 4%, and 2% sequestration reduction from January through June 2021

Medicare Part C	Medicare Part D	Medi-Cal**
CMS CY 2019 rate report* Draft CY 2020 rates • Forecasted a 0.7% increase in revenue	CMS CY 2019 rate report Draft CY 2020 rates • Forecasted a 2.0% decrease in revenue	N/A Draft CY 2019 rates • Adjusts for forecasted population mix

* OCC Medicare rates are not developed from a bid process that uses actual plan data; used most current county benchmark base rate available

** DHCS plan rates uses Rate Development Template (RDT) base data that has a two-year lag

OneCare Connect Assumptions

- Enrollment: Applied projected mix for PHC, SRG, HMO, and CCN networks
- Medical Costs
  - Provider Capitation
    - Medicare component: Based on percent of premium (POP) rates
    - Reduced Institutional POP% per Milliman rebasing results from 50.9% to 45%. Annual impact of $7.4 million ($3.7 million for FY 2020-21)
    - Medi-Cal component: Based on fixed PMPM rates
  - FFS expenses: Based on actual experience trended through June 2020
- Other adjustments
  - Includes projected increases in NMT, specialist services, acute inpatient, facility, pharmacy, and projected decrease in LTC expenses.
  - Includes expenses for Medicare supplemental benefits to align with OneCare supplemental benefits

OCC Current Challenges

- Challenges
  - CMS applies revenue reductions, including savings targets, a quality withhold and sequestration
  - No formal bid process; rates are set at the county FFS benchmark and do not reflect actual plan costs
  - Risk Adjustment Factors reflect difficulties with proper data submission processes
  - Increased costs due to additional supplemental benefits
  - Disenrollment rate greater than enrollment rate
  - CMS will continue to apply disenrollment penalties
- Current initiatives and actions
  - Implemented capitation rate adjustments to Health Networks through rebasing
  - Outsource CMS data submissions using an external vendor
  - Implementing the Primary Care Engagement and Clinical Documentation Integrity Program

OneCare Program

Start Date	October 2005
Program Type	Medicare Advantage Special Needs Plan (SNP)
Contractor/ Regulator	Centers for Medicare & Medicaid Services (CMS)
Eligibility	Medi-Cal member who also has Medicare (i.e., dual eligible)
Services	• Comprehensive health • Prescriptions • Vision • Mental Health • Supplemental Benefits

OneCare Budget

	FY 2018-19 Actual	FY 2019-20 Forecast*	FY 2020-21 Budget
Average Monthly Enrollment	1,448	1,481	1,378
Revenue	$20,613,605	$20,496,838	$19,472,782
Medical Costs	$18,272,702	$18,295,185	$17,827,723
Administrative Expenses	$1,375,766	$1,710,002	$1,646,834
Operating Income/Loss	**$965,137**	**$491,651**	**(1,774)**
Medical Loss Ratio	88.6%	89.3%	91.6%
Administrative Loss Ratio	6.7%	8.3%	8.5%

* Forecasted as of March 2020

OneCare Assumptions

- OneCare rate assumptions

Medicare Part C	Medicare Part D
CMS CY 2020 Monthly Membership Report actuals • Forecasted 4% decrease to revenue as lower utilization last year will translate to lower revenue in bid process	CMS CY 2020 Monthly Membership Report actuals • Forecasted 6% increase as compared to prior year (primarily RAF score driven)

Note: Used most current rate available

- Medical Costs
  - ➢ Professional provider capitation: Based on 38.6% POP
  - ➢ Includes expenses for approved supplemental benefits

PACE Program

Start Date	October 2013
Program Type	Medicare and Medicaid Program
Contractor/ Regulator	CMS and DHCS
Eligibility	Member who is: • ≥ 55; • Meet nursing facility level of care; and • Live in a PACE service area
Services	• All Medicare and Medicaid services • 16 additional services, such as social services, nursing facility care, personal care, nutritional counseling and recreational therapy

PACE Budget

Program	FY 2018-19 Actual	FY 2019-20 Forecast*	FY 2020-21 Budget
Average Monthly Enrollment	303	374	434
Revenue	$27,410,747	$36,281,926	$42,189,583
Medical Costs	$23,297,733	$29,410,640	$37,731,523
Administrative Expenses	$1,765,267	$2,044,756	$2,002,647
Operating Income/Loss	**$2,347,747**	**$4,826,530**	**$2,455,414**
Medical Loss Ratio	85.0%	81.1%	89.4%
Administrative Loss Ratio	6.4%	5.6%	4.7%

* Forecasted as of March 2020

PACE Assumptions

- PACE rate assumptions

Medicare Part C	Medicare Part D	Medi-Cal
2020 Actuals • Forecasted a 7.1% increase in revenue due to both base rates and RAF score	2020 Actuals • Rates and subsidies based on CY 2020 payment • No additional trend applied	PMPM rates based on CY 2019 rates and reflect a 2.2% increase

Note: Used most current rate available

- Medical costs
  - Based on mix of actual experience and industry benchmarks
  - Reclassifies 96% of some administrative expenses as medical costs to better reflect the actual costs of delivering medical care

Recommended Actions

1. Approve CalOptima FY 2020-21 Operating Budget
2. Authorize the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details
   - Items will be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy











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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
9. Consider Approval of the CalOptima Fiscal Year 2020-21 Capital Budget

Contact
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions
1. Approve the CalOptima Fiscal Year (FY) 2020-21 Capital Budget; and
2. Authorize the expenditures and appropriate the funds for the items listed in Attachment A: Fiscal Year 2020-21 Capital Budget by Project, which shall be procured in accordance with CalOptima's Board-approved policies.

Background
As of March 31, 2020, CalOptima recorded gross capital assets of $92.8 million in the 505 Building, building improvements, furniture, equipment, and information systems. To account for these fixed assets wearing out over time, Staff has charged against the cost of these assets an accumulated depreciation totaling $51.4 million. Staff will record capital assets acquired in FY 2020-21 at acquisition cost and will depreciate the value on a straight-line basis over their estimated useful lives as follows:

- Five (5) years for office furniture and fixtures;
- Three (3) years for computer equipment and software;
- The lesser of fifteen (15) years or remaining term of lease for leasehold improvements; and
- Ten (10) to twenty (20) years based on components for building improvements.

The resulting net book value of these fixed assets was $41.4 million as of March 31, 2020. Prior Board-approved capital budgets were $11.0 million in FY 2019-20, and $9.8 million in FY 2018-19.

Pursuant to CalOptima Policies GA. 3202: CalOptima Signature Authority, GA. 5002: Purchasing Policy, and GA. 5003: Budget and Operations Forecasting, the Board's approval of the budget authorizes the expenditure of the item and appropriates the funds requested without further Board action to the extent the Board has or is, as indicated in the budget attachments, delegating authority to Management.

Discussion
Management proposes a Capital Budget of $16.2 million for FY 2020-21 for the following asset types within three (3) asset categories summarized in the following table and detailed below:

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Category	Amount	% of Total
1. Information Systems		
Hardware	$3,883,000	23.9%
Software	$7,719,000	47.6%
Professional fees related to implementation	$2,879,000	17.7%
Subtotal	$14,481,000	89.2%
2. 505 Building Improvements	$1,636,000	10.1%
3. PACE	$119,000	0.7%
Total	**$16,236,000**	**100.0%**

1. Information Systems

Information Systems represent nearly $14.5 million or 89.2% of the proposed Capital Budget. This asset category primarily addresses CalOptima's information technology infrastructure needs.

Project Type	Amount	% of Total
Infrastructure	$2,198,000	15.2%
Applications Management	$10,370,000	71.6%
Applications Development	$1,913,000	13.2%
Total	**$14,481,000**	**100.0%**

The Capital Budget includes hardware, software, and professional fees related to implementation to fund multiple systems upgrades. More detailed information is provided in Attachment A: Fiscal Year 2020-21 Capital Budget by Project. These upgrades are necessary to support internal operations, and to continue to comply with state and federal statutory, regulatory and contractual requirements.

2. 505 Building Improvements

Proposed 505 Building Improvements represent $1.6 million or 10.1% of the Capital Budget. The largest item of $415,000 or 25.4% of the 505 Building capital expenditures is to fund Office Renovations.

Project Type	Amount	% of Total
Office Renovations (Cubicle Reconfigurations)	$415,000	25.4%
Multiple Bathroom Upgrades (Original Bathrooms on 2nd and 4th Floors)	$375,000	22.9%
Lobby Security Improvements (Safety Barrier and Customer Service Room Reconfiguration)	$300,000	18.4%
1st Floor Conference Rooms Audio Visual System Upgrade	$135,000	8.3%
Cooling Tower Continuation	$80,000	4.9%
Copier Replacements and Lease	$75,000	4.6%
Sink Heating Installation for Restrooms Floors 5-10	$50,000	3.1%
Conference Rooms Audio Visual System Upgrade (5th and 9th Floors)	$42,000	2.6%
Ground Floor Corridor Heating and Cooling Boxes Replacement	$35,000	2.1%
IDF Room HVAC Continuation	$25,000	1.5%

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Project Type	Amount	% of Total
Ceiling Replacement in Passenger Elevators	$25,000	1.5%
Building Security Cameras Upgrade	$22,000	1.3%
1st Floor Card Reader Addition	$20,000	1.2%
Replacement of Trash Room Double Doors with Fire Rated Doors	$15,000	0.9%
Domestic Water Circulation Pump Replacement	$12,000	0.7%
Recording Studio	$10,000	0.6%
Total	**$1,636,000**	**100.0%**

3. Program for All-Inclusive Care for the Elderly (PACE)
The remaining portion of $119,000 or 0.7% of the proposed Capital Budget is for capital expenditures at the PACE Center.

Project Type	Amount	% of Total
Workspace Efficiency and Expansion	$57,000	47.9%
Rehab Equipment	$15,000	12.6%
Audiovisual and Conference Room	$12,000	10.1%
Lobby Refurbishment	$10,000	8.4%
Clinic Doors Handicap Access	$7,000	5.9%
Internal Staff Communication	$6,000	5.0%
Clinic Spirometer	$5,000	4.2%
Commercial Freezer	$5,000	4.2%
Exterior Electricity	$2,000	1.7%
Total	**$119,000**	**100.0%**

Fiscal Impact
Investment in the proposed Capital Budget will reduce CalOptima's investment principal by $16,236,000. At a 1% return rate, this would reduce annual interest income by approximately $162,360. Depreciation expense for Information Systems and 505 Building Improvements is reflected in CalOptima's Operating Budget.

Rationale for Recommendation
The proposed FY 2020-21 Capital Budget will enable necessary system upgrades, enhance operational efficiencies, support strategic initiatives, comply with federal and state requirements, and improve and upgrade the 505 Building and the PACE Center.

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

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Attachment

Attachment A: Fiscal Year 2020-21 Capital Budget by Project

/s/ Richard Sanchez *05/27/2020*

Authorized Signature **Date**

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Attachment A

Fiscal Year 2020-21 Capital Budget by Project

INFRASTRUCTURE	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Internet Firewall Protection Server Upgrade	450,000			450,000
505 Building Wireless System Upgrade	430,000			430,000
New IT Asset Management Application	100,000	150,000	50,000	300,000
User Identity and Access Management Application	70,000		200,000	270,000
Core Operational Server Upgrade (Blade Servers)	200,000			200,000
Business Partner End to End Virtual Private Network Upgrade	160,000			160,000
CalOptima Internal Network Firewall Protection Server Upgrade	150,000			150,000
Remote Work Secure Connection Token Upgrade	93,000			93,000
Data Warehouse Disk Storage Array Upgrade and Replacement	54,000			54,000
Call Center Telephony Upgrade	25,000	25,000		50,000
PACE Network Router Replacement	19,000			19,000
Storage Area Network Switch Ports Expansion	13,000			13,000
Virtual Machine VM Blade Switch Enclosures Upgrade	9,000			9,000
TOTAL INFRASTRUCTURE	**$ 1,773,000**	**$ 175,000**	**$ 250,000**	**$ 2,198,000**

APPLICATIONS MANAGEMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
CMS Interoperability and Patient Access System Implementation	250,000	1,750,000	500,000	2,500,000
Care Management System Implementation	250,000	1,500,000	500,000	2,250,000
Core Administration System Enhancement	125,000	1,150,000	500,000	1,775,000
Claims Pricer Integration Software		1,000,000	200,000	1,200,000
Provider Data Management Solution	250,000	750,000	125,000	1,125,000
Claims Payment Automation System Upgrade		450,000	100,000	550,000
Managed Care Predictive Analytics and Data Modeling		400,000	100,000	500,000
Hardware Upgrade for Computer Robotic Workflow	200,000			200,000
Provider Credentialing Integration to the Core Administration System	70,000		100,000	170,000
Additional Memory, CPU and Disc Space	50,000			50,000
Additional Storage Server Equipment	50,000			50,000
TOTAL APPLICATIONS MANAGEMENT	**$ 1,245,000**	**$ 7,000,000**	**$ 2,125,000**	**$ 10,370,000**

APPLICATIONS DEVELOPMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Provider Portal Referral Documentation File Server Infrastructure	550,000	35,000	60,000	645,000
CalOptima.org Web Content Management Server Upgrade	125,000	100,000	200,000	425,000
Litigation Hold and Discovery Applications		350,000		350,000
Enterprise Content Management System Consultation and Build			200,000	200,000
Data Governance and Meta Data Management Enhancement	60,000	50,000	24,000	134,000
Hardware to Support Portal Security Audit Reporting	60,000			60,000
Hardware to Support Financial HIPAA X12 Data Analysis	60,000			60,000
Application Development Source Code Foundation Server Replacement	10,000	9,000	20,000	39,000
TOTAL APPLICATIONS DEVELOPMENT	**$ 865,000**	**$ 544,000**	**$ 504,000**	**$ 1,913,000**

505 BUILDING IMPROVEMENTS	BUILDING	EQUIPMENT	PROFESSIONAL FEES	TOTAL CAPITAL
Office Renovations (Cubicle Reconfigurations)	380,000		35,000	415,000
Multiple Bathroom Upgrades (Original Bathrooms on 2nd and 4th Floors)	300,000		75,000	375,000
Lobby Security Improvements (Safety Barrier and Customer Service Room Reconfiguration)	250,000		50,000	300,000
1st Floor Conference Rooms Audio Visual System Upgrade	110,000		25,000	135,000
Cooling Tower Continuation	80,000			80,000
Copier Replacements and Lease	75,000			75,000
Sink Heating Installation for Restrooms Floors 5-10	50,000			50,000
Conference Rooms Audio Visual System Upgrade (5th and 9th Floors)	37,000		5,000	42,000
Ground Floor Corridor Heating and Cooling Boxes Replacement	35,000			35,000
IDF Room HVAC Continuation	20,000		5,000	25,000
Ceiling Replacement in Passenger Elevators	25,000			25,000
Building Security Cameras Upgrade	22,000			22,000
1st Floor Card Reader Addition	20,000			20,000
Replacement of Trash Room Double Doors with Fire Rated Doors	15,000			15,000
Domestic Water Circulation Pump Replacement	12,000			12,000
Recording Studio	10,000			10,000
TOTAL 505 BUILDING IMPROVEMENTS	**$ 1,441,000**	**$ -**	**$ 195,000**	**$ 1,636,000**

PACE	EQUIPMENT		PROFESSIONAL FEES	TOTAL CAPITAL
Workspace Efficiency and Expansion	57,000	-	-	$57,000
Rehab Equipment	15,000	-	-	$15,000
Audiovisual and Conference Room	12,000	-	-	$12,000
Lobby Refurbishment	10,000	-	-	$10,000
Clinic Doors Handicap Access	7,000	-	-	$7,000
Internal Staff Communication	6,000	-	-	$6,000
Clinic Spirometer	5,000	-	-	$5,000
Commercial Freezer	5,000	-	-	$5,000
Exterior Electricity	2,000	-	-	$2,000
TOTAL PACE	**$ 119,000**	**$ -**	**$ -**	**$ 119,000**

TOTAL FY 2020-21 CAPITAL BUDGET	**$ 5,443,000**	**$ 7,719,000**	**$ 3,074,000**	**$ 16,236,000**

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FY 2020-21 Capital Budget

Capital Budget by Category

Overview of Capital Budget

Category	FY 2020-21 Budget	% of Total
Information Systems		
Hardware	$3,883,000	23.9%
Software	$7,719,000	47.6%
Professional fees related to implementation	$2,879,000	17.7%
Subtotal	$14,481,000	89.2%
505 Building Improvements	$1,636,000	10.1%
PACE	$119,000	0.7%
Total	**$16,236,000**	**100.0%**

- Departments submit requests for capital projects based on strategic and operational needs
- Information Services Department reviews technology requests

Information Systems Budget

Project Type	FY 2020-21 Budget
Infrastructure (e.g., Network, Server, Storage, Security)	$2,198,000
Applications Management (e.g., CMS Interoperability and Patient Access System Implementation, Care Management System Implementation, Core Administration System Enhancement)	$10,370,000
Applications Development (e.g., Provider Portal Referral Documentation File Server Infrastructure, CalOptima.org Web Content Management Server Upgrade, Litigation Hold and Discovery Applications)	$1,913,000
Total	**$14,481,000**

- Represents nearly 89.2% of total Capital Budget
- Addresses information technology infrastructure needs
- Supports internal operations
- Ensures compliance with state and federal statutory, regulatory and contractual requirements

505 Building Improvements

Project Type	FY 2020-21 Budget
Office Renovations (Cubicle Reconfigurations)	$415,000
Multiple Bathroom Upgrades (Original Bathrooms on 2nd and 4th Floors)	$375,000
Lobby Security Improvements (Safety Barrier and Customer Service Room Reconfiguration)	$300,000
1st Floor Conference Rooms Audio Visual System Upgrade	$135,000
Cooling Tower Continuation	$80,000
Copier Replacements and Lease	$75,000
Sink Heating Installation for Restrooms Floors 5-10	$50,000
Conference Rooms Audio Visual System Upgrade (5th and 9th Floors)	$42,000
Ground Floor Corridor Heating and Cooling Boxes Replacement	$35,000
IDF Room HVAC Continuation	$25,000
Ceiling Replacement in Passenger Elevators	$25,000
Building Security Cameras Upgrade	$22,000
1st Floor Card Reader Addition	$20,000
Replacement of Trash Room Double Doors with Fire Rated Doors	$15,000
Domestic Water Circulation Pump Replacement	$12,000
Recording Studio	$10,000
Total	**$1,636,000**

PACE Center Budget

Project Type	FY 2020-21 Budget
Workspace Efficiency and Expansion	$57,000
Rehab Equipment	$15,000
Audiovisual and Conference Room	$12,000
Lobby Refurbishment	$10,000
Clinic Doors Handicap Access	$7,000
Internal Staff Communication	$6,000
Clinic Spirometer	$5,000
Commercial Freezer	$5,000
Exterior Electricity	$2,000
Total	**$119,000**

Recommended Actions

1. Approve the CalOptima FY 2020-21 Capital Budget
2. Authorize the expenditure and appropriate the funds for items listed in Attachment A: Fiscal Year 2020-21 Capital Budget by Project
   - Items will be procured in accordance with CalOptima policies

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Approval of Remedial Actions Related to Health Network and Provider Overpayments Arising from Medi-Cal Member Eligibility Reporting Error

Contact

Nora Onishi, Director Information Services (714) 246-8400
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO) to waive the recovery of additional overpayments made to Health Networks and Providers for the period of August 1, 2014 through August 30, 2018 based on a System Coding Logic Error and make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose.

Background

The Department of Health Care Services (DHCS) regularly sends Medi-Cal Member eligibility information to CalOptima. Medi-Cal eligibility files contains current month newly eligible and terminated Members plus 12 months of historical eligibility. Based on the information provided, CalOptima processes these files as they are received from DHCS to update its member eligibility and demographic information. Once the files are processed in CalOptima's systems, staff generates Medi-Cal member eligibility reporting for contracted Health Networks.

In September 2019, CalOptima's Information Systems (IS) team identified an internal coding discrepancy ("System Coding Logic Error") that directly impacted Medi-Cal member eligibility reporting. Specifically, while the system appropriately reported retroactive terminations due to member death or that were manually processed, retroactive termination based on other criteria (e.g., loss of eligibility via reporting by DHCS) were not captured. This resulted in overstated eligibility reports that, in turn, impacted the reported number of Medi-Cal eligible members assigned to CalOptima's Health Networks and fee-for-service providers. For example, if DHCS's September 2019 eligibility file reported a member terminated as of July 1, 2019, due to loss of eligibility, the CalOptima system recorded the termination as of September 1, 2019, missing two prior months of ineligibility.

Because Health Network capitation payments are issued based on the Members assigned to that Health Network, this error ultimately resulted in the overpayment of monthly Medi-Cal capitation. Since CalOptima did not register some of the retroactive eligibility termination information and recoup capitation payments from the Health Networks, the Health Networks, in turn, did not recoup payments from their providers for the impacted members.

The State's eligibility file contains current month eligibility plus 12 months of historical eligibility and terminations information. For the 12 months prior to the issue being identified in September 2019, it is estimated that CalOptima overpaid $2.8 million in Medi-Cal capitation to its Health Networks and $2.4 million in fee-for-service claims. Based on the available 12 months of historical Medi-Cal eligibility

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information at the time the coding discrepancy was identified, CalOptima was able to update its internal business systems with the retroactive terminations back to September 2018. Since the update, CalOptima has been following recoupment processes to recover fee-for-service claims payments issued for dates of service from September 1, 2018 forward. Recoupments for overpaid capitation to Medi-Cal Health Networks were processed for payments dating back to April 1, 2019. To ensure consistency with recoupment processes for CalOptima Direct providers, recoupments for capitation payments to the health networks similarly need to be processed going back an additional seven months to September 1, 2018.

Resolution of the Discrepancy: In response to the coding discrepancy, CalOptima's IS Department implemented two (2) sets of controls designed to prevent future reoccurrence of the issue. The controls include code changes that were programmed into CalOptima's core system and processes to validate eligibility data with the monthly eligibility file received from the State. The code changes allow the system to recognize and process all retroactive eligibility terminations timely within the normal capitation cycle, and consistent with DHCS member termination data. To ensure quality control, the IS Department simultaneously runs monthly full-file reconciliations against thirteen (13) months of DHCS member eligibility data (current month plus twelve (12) prior months).

Additionally, new data controls are currently being developed so that the eligibility data will be compared to the capitation data received by DHCS for another level of validation. The internal process for receiving and passing on the eligibility and termination information from the State to CalOptima's providers and Health Networks will be selected for a focused internal audit. These quality controls are intended to ensure that CalOptima's monthly eligibility information and Health Network capitation payments are aligned with timely updated member eligibility data received from DHCS. CalOptima staff will complete the reconciliation of corrective actions related to the System Coding Logic Error and capitation payments to the Health Networks by no later than June 30, 2020.

Discussion

When the coding discrepancy was identified, CalOptima staff began analysis of the issue and developed resolution plans. CalOptima's system has been updated so that it now captures all retroactive termination information going back twelve (12) months (consistent with DHCS's eligibility file) and passes the information on to the contracted Health Networks. However, based on the current system logic for capitation payments and the span of monthly retroactive termination information received from the State, CalOptima has only recouped capitation payment from the Health Networks back to April 2019.

In light of the System Coding Logic Error impacting reporting of the retroactive member terminations to the Health Networks, and consistent with the fee-for-service claims recoupments based on available Medi-Cal eligibility information, staff is seeking Board authorization to waive recoupments of any additional overpaid capitation or fee-for-service amounts for the period prior to September 1, 2018. The average yearly cost of waiving the recoupments is estimated at $2.8 million per year for the Health Networks and $2.4 million per year for fee-for-service providers over a four-year period.

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Staff is therefore requesting that the Board authorize limiting additional recoupments to the period of September 1, 2018 through June 30, 2020, when the final reconciliation of the Health Network capitation and retroactive eligibility will be completed. Staff foresees that any further recoupment efforts prior to September 2018 would likely result in the Health Networks and CalOptima having challenges identifying and recouping the funds from downstream providers. As the Health Networks, providers, and members continue to be impacted by the financial challenges resulting from the COVID 19 pandemic, staff believes these measures will mitigate the impact.

Fiscal Impact

The recommended action to waive the recovery of additional overpayments made to Health Networks and providers via shared-risk and direct network fee-for-service claims related to a system coding logic error prior to September 1, 2018 will have no impact to CalOptima's prior year net assets. The recommended action is not projected to impact CalOptima's Fiscal Year 2019-20 Operating Budget, approved by the Board on June 6, 2019.

Management estimates the annual amount of overpayment is $2.8 million in capitation to Health Networks, and $2.4 million in fee-for-service payments. The fiscal impact over the recommended action period is approximately $11.2 million in capitation to Health Networks, and $9.6 million in fee-for-service payments.

Rationale for Recommendation

CalOptima staff is proposing to align the retroactive eligibility termination information received from the State (up to twelve months) with the capitation payments made to the Health Networks and limit the recoupment of the additional overpayments, going back beyond a year from the date the System Coding Logic Error was identified, in order to remain consistent with the current regulatory practice of eligibility submission. With this approach, and in light of the current public health crisis brought on by the COVID-19 pandemic, management believes the recommended action will both address the overpayment issue and ensure that Health Networks and providers are available to meet Members' healthcare needs.

Concurrence

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

Attachments

None

/s/ Richard Sanchez — *05/27/2020*
Authorized Signature — **Date**

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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

11. Consider Actions Related to Intergovernmental Transfer (IGT) 5, 6 and 7 Community Grant Contracts in Response to COVID-19

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action(s)

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend contract agreements with IGT 5, 6 and 7 community grantees to allow for the following when applicable:

a. No-Cost time extension to the grants for the purpose of completing workplan deliverables;
b. Temporary modifications to the Scope of Work to include a modified delivery of service when the request does not impact the objective or number of members served; and/or
c. Revisions to the budget line item due to statutory changes; changes in direct response to COVID-19 new guidelines, or to address the temporary modification in Scope of Work.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in nine Rate Range IGT transactions. Funds from IGTs 1 through 9 have been received and IGT 10 funds are expected from the state in the first quarter of 2022. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2010-2011 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to the Centers for Medicare & Medicaid Services (CMS).

The IGT funds received under IGT 1 through 7 have supported special projects that address unmet health care needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless CalOptima members, and support for members through the Personal Care Coordinator (PCC) program. These funds have typically been used for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.
On August 1 and October 3, 2019, the CalOptima Board of Directors authorized community grants funded through IGT 5, 6 and 7 in seven priority areas:

- Expand Access to Outpatient Children's Mental Health Services;
- Integrate Children's Mental Health Services into Primary Care;
- Increase Access to Medication-Assisted Treatment;
- Expand Access to Food Distribution Services Focused on Children and Families;
- Access to Children's Dental Services;
- Access to Adult Dental Services; and
- Primary Care Services and Programs Addressing Social Determinants of Health.

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Twelve community grants were awarded to 11 organizations, with one organization receiving two grants in separate categories.

On February 27, 2020, Orange County declared a local health emergency related to COVID-19 and the Governor of California declared a State of Emergency on March 4, 2020. On March 11, 2020, the World Health Organization declared the coronavirus a pandemic. On March 13, 2020, the President declared a national emergency based on the spread of the coronavirus. While social distancing has been encouraged to limit the spread of COVID-19, beginning March 17, 2020 local and state agencies began implementing stay-at-home orders to prohibit professional, social, and community gatherings outside a list of "essential activities". Subsequently, CMS announced that all elective surgeries, non-essential medical, surgical, and dental procedures be delayed during the pandemic. In response, CalOptima staff distributed a general message on March 26, 2020 to the grantees acknowledging COVID-19 might have a potential impact on the deliverables for each grant.

Discussion

Due to the stay-at-home orders and regulatory guidance, most of the IGT grantees have had to curtail grant activities on new initiatives to focus efforts to respond to the immediate crisis until after the current emergency is over. CalOptima staff conducted calls with grantees to discuss how the crisis has impacted their organization and the grant deliverables, and if any steps are being considered to address potential delays or issues caused by the crisis. As a result, staff has received requests for accommodations of their grant agreements, that include:

- No-cost extensions: Extend due dates for deliverables and grant completion at no additional costs until the grantee is able to resume services based on orders or guidelines set forth by Federal, State, or Local authorities and grantee organizational capacities;
- Revised budget line items: Move budgeted amounts between line items with no change to the overall budget; and/or
- Temporary modifications to scope of work: Modifications to the scope of work to allow for different modes of providing deliverables, such as temporarily providing telehealth or teledentistry in lieu of in-person care.

Based on the requests from the grantees, staff proposes below actions for the following grantees, where indicated, to address the impact to the grant deliverables:

Funding Category	IGT #	Grantee	Project Length	Contract Start Date	Total Grant Amount	Recommended Action(s)
1. Children's Dental Services	5	Coalition of Orange County Community Health Centers	2 years	10/1/2019	$500,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19

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	Funding Category	IGT #	Grantee	Project Length	Contract Start Date	Total Grant Amount	Recommended Action(s)
2.	**Children's Dental Services**	5	Healthy Smiles for Kids of Orange County	1 year	2/1/2020	$500,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19
3.	**Primary Care Services and Social Determinants of Health**	5	Santa Ana Unified School District	3 years	10/1/2019	$1,400,000	No specific action requested at this time
4.	**Adult Dental Services**	5	KCS Health Center (Korean Community Services)	1 year	10/1/2019	$1,000,000	Provide temporary modification in Scope of Work to allow alternate delivery of service (tele-dentistry) due to regulatory guidelines as a result of COVID-19
5.	**Outpatient Children's Mental Health Services**	6/7	Children's Bureau of Southern California	2 years	12/1/2019	$3,390,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19
6.	**Outpatient Children's Mental Health Services**	6/7	Orange County Asian & Pacific Islander Community Alliance, Inc (OCAPICA)	3 years	10/1/2019	$685,000	No specific action requested at this time
7.	**Outpatient Children's Mental Health Services**	6/7	Boys & Girls Clubs of Garden Grove	3 years	10/1/2019	$325,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19
8.	**Outpatient Children's Mental Health Services**	6/7	Jamboree Housing Corporation	2 years	10/1/2019	$450,000	No specific action requested at this time
9.	**Integrate Children's Mental Health Services**	6/7	CHOC Children's	3 years	10/1/2019	$4,250,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19

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Funding Category	IGT #	Grantee	Project Length	Contract Start Date	Total Grant Amount	Recommended Action(s)
10. Integrate Children's Mental Health Services	6/7	Friends of Family Health Center	2 years	10/1/2019	$600,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19
11. Increase Access to MAT	6/7	Coalition of Orange County Community Health Centers	3 years	10/1/2019	$6,000,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19 and budget line item revision due to a recent change in regulatory guidelines that eliminated an added procurement expense for the drug Narcan
12. Food Distribution Services Children and Families	6/7	Serve the People	2 years	10/1/2019	$1,000,000	Provide temporary modification in Scope of Work to allow for home delivery, budget line item revision to allow for the purchase of food, and no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19

Fiscal Impact

The recommended action to amend contract agreements with IGT 5, 6, and 7 community grantees has no additional fiscal impact to IGT expenditures, as authorized through previous Board actions. IGT funds are for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's commitment in working Better. Together, and as the Medi-Cal health plan for Orange County, CalOptima continues to work with our provider and community partners to address the needs of our members, by working to improve the availability, access and quality of health care services.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by the Recommended Action
2. CalOptima Board Action dated August 1, 2019, Consider Allocation of Intergovernmental Transfer 6 and 7 Funds
3. CalOptima Board Action dated August 1, 2019, Consider Allocation of Intergovernmental Transfer 5 Funds
4. CalOptima Board Action dated October 3, 2019, Consider Allocation of Intergovernmental (IGT) 5 Funds Towards a Community Grant(s) for Access to Children's Dental Services

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

	Name	Medical Group	Address	City	State	Zip Code
1.	Boys & Girls Clubs of Garden Grove	NA	10540 Chapman Ave.	Garden Grove	CA	92840
2.	Children's Bureau of Southern California	NA	50 Anaheim Blvd. Ste. 241	Anaheim	CA	92805
3.	CHOC Children's	CHOC Health Alliance	1201 W. La Veta Ave.	Orange	CA	92868
4.	Coalition of Orange County Community Health Centers*	NA	515 N. Cabrillo Dr. Ste. 225	Santa Ana	CA	92701
5.	Friends of Family Health Center		501 South Idaho Street	La Habra	CA	90631
6.	Healthy Smiles for Kids Orange County	NA	10602 Chapman Ave. Ste. 200	Garden Grove	CA	92840
			2010 E. Fourth Street, Ste. A220	Santa Ana	CA	92705
7.	Jamboree Housing Corporation	NA	17701 Cowan Ave., Ste. 200	Irvine	CA	92614
8.	KCS Health Center (Korean Community Services)		7212 Orangethorpe Ave. Ste 9A	Buena Park	CA	90621
9.	Orange County Asian & Pacific Islander Community Alliance, Inc	NA	12912 Brookhurst Street Ste. 410	Garden Grove	CA	92840
10.	Santa Ana Unified School District	NA	1061 East Chestnut Ave.	Santa Ana	CA	92701
11.	Serve the People		1206 17th Street	Santa Ana	CA	92701

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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
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.

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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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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.

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OneCare Connect
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PACE
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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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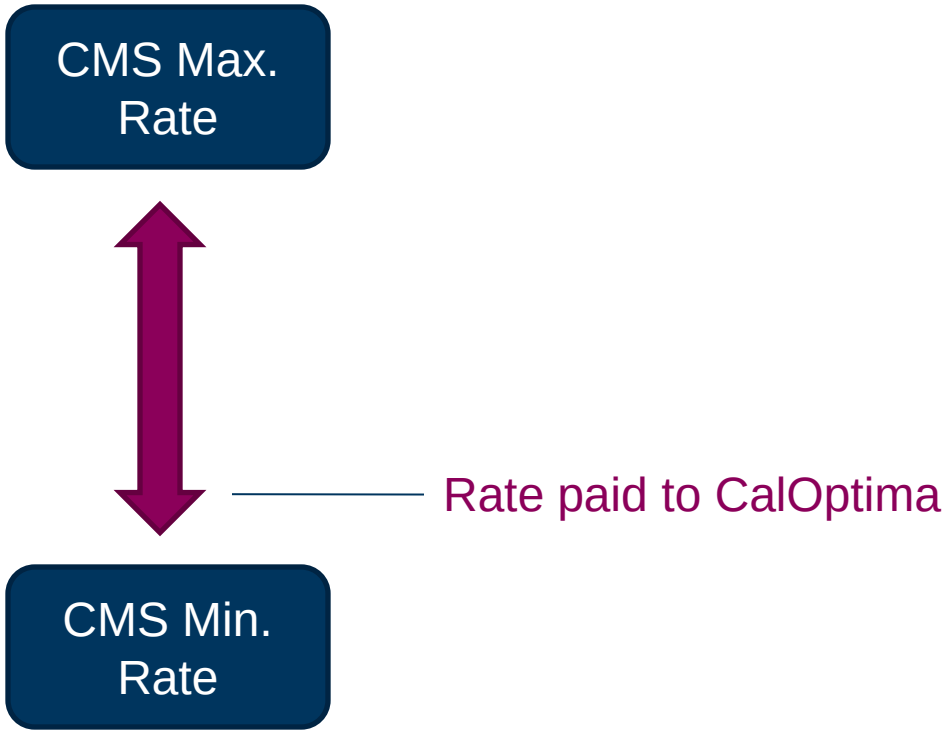
Intergovernmental Transfers (IGT) Background

- 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**

Rev. 9/6/18

Internal Projects and Program Administration

In addition, staff is also recommending an allocation of approximately $3.4 million for internal projects and IGT program administration to manage all IGT program projects as follows:

Internal Project Examples: - IS and other infrastructure projects	$2,500,000
IGT Program Administration - Support for two (2) existing staff positions for three years - Grant Management System license, and other administrative costs for three years	$949,289 *(Approx. $317,000 per year for three years)*
TOTAL	**$3,449,289**

Staff anticipates returning with recommendations of RFP grantee awards and internal project(s) for Board approval following the completion of the community grant and internal project RFP application processes at the February 2019 Board meeting. The staff positions are Manager, Strategic Development, and Program Assistant, and the above proposed funding is in addition to $10 million allocated from IGT 6/7 for Homeless Health on August 2, 2018.

Fiscal Impact

The recommended action to approve the expenditure plan and allocation of $21.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT 6 & 7 Expenditure Plan Allocation

/s/ Michael Schrader — **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 August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Allocation of Intergovernmental Transfer 5 Funds

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions

Rev. 8/1/19

1. Approve the amended recommended allocations of IGT 5 funds in the total amount of $2.4 million ~~3.4 million~~ for RFP 2., Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics) and RFP 3., Adult Dental Services for community grants; and,
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute grant contracts with the recommended community grantees.
3. The Board directed staff to bring back details of applications submitted for Request for Proposal (RFP) Category 1., Access to Children's Dental Services for a funding amount of $1 Million, including criteria, evaluations, scoring sheets, and qualifications for further review at its September 5, 2019, Board of Directors meeting.

Background

Intergovernmental Transfers (IGTs) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT 1-7 funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus IGT 1-7 funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries. Beginning with IGT 8, the IGT funds are viewed by the state as part of the capitation payments CalOptima receives; these payments are to be tied to covered Medi-Cal services provided to Medi-Cal beneficiaries.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net.

On December 1, 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) the results of which would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per the approved priority areas. The MHNA data collection activities were completed in November 2017.

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On February 1, 2018, a summary of MHNA results was shared with the CalOptima Board of Directors. Based on the results of the MHNA, the Board additionally approved the release of eight RFPs for $14.4 million community grants in the following categories:

- Adult Mental Health
- Older Adult Mental Health
- Children's Mental Health
- Nutrition Education and Physical Activity
- Children's Dental Services
- Medi-Cal Benefits Education and Outreach
- Primary Care Access and Social Determinants of Health
- Adult Dental Services

In preparation for the release of the RFPs, staff recognized a need to narrow and better define a more precise and definitive Scope of Work (SOW) for each category. On June 7, 2018, the CalOptima Board approved release of Requests for Information related to these eight categories; ninety-three responses in July 2018.

On December 6, 2018, the CalOptima Board of Directors approved $11.4 million of IGT 5 funds to the Be Well Wellness Hub in December 2018. At that time, the Board of Directors also approved the release of the three following RFPs in the total amount of $3.4 million ($3 million remaining in IGT 5 and $400,000 reallocated from IGT 2) for community grants.

Request for Proposal	Priority Area	Allocation Amount
1. Access to Children's Dental Services	Strengthening the Safety Net	$1.0 million
2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	Strengthening the Safety Net	$1.4 million
3. Adult Dental Services	Strengthening the Safety Net	$1.0 million

The three RFPs garnered 20 responses. External subject matter experts and staff performed an examination of all the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

The IGT 5 Ad Hoc committee comprised of Dr. Nikan Khatibi and Dr. Alexander Nguyen met on July 23, 2019 to discuss the results of the 20 RFP responses for Children's Dental Services, Primary Care Services and Programs Addressing Social Determinants of Health, and Adult Dental Services. Following the review of the evaluation committee results, the Ad Hoc committee is recommending the following allocation of $3.4 million for IGT 5 board-approved priority areas through three (3) RFPs.

Community Grants

Category	Organization	Funding Amount
RFP 1. Access to Children's Dental Services	Healthy Smiles for Kids of Orange County	$1,000,000
RFP 2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	Santa Ana Unified School District	$1,400,000
RFP 3 Adult Dental Services	KCS Health Center (Korean Community Services)	$1,000,000

Fiscal Impact

The recommended action to approve the allocation of $3.4 million from IGT 5 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: IGT 5 Expenditure Plan Allocation
2. CalOptima Board Action dated February 1, 2018, Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants
3. CalOptima Board Action dated June 7, 2018, Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)
4. CalOptima Board Action dated December 6, 2018, Consider Authorizing a Contract for Be Well Wellness Hub Services Provided to CalOptima Medi-Cal Members using Intergovernmental Transfer (IGT) 5 Funds
5. CalOptima Board Action dated December 6, 2018, Consider Authorizing Release of Requests for Proposal (RFPs) for Community Grants to Address Categories from the Intergovernmental Transfer (IGT) 5 Funded CalOptima Member Health Needs Assessment and Authorizing Reallocation of IGT 2 Funds.
6. List of responders by RFP category.

Authorized Signature **Date**

IGT 5 Community Grant Award Consideration

Board of Directors Meeting

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 5 priority areas for community-based funding opportunities
  - Childhood Obesity
  - Mental Health (Adult and Children's)
  - Improving Children's Health
  - Strengthening the Safety Net

IGT 5 Background Summary

Board authorized Member Health Needs Assessment (MHNA) to guide expenditure of IGT5 funds

MHNA identified categories for community grants

Board authorized Requests for Information (RFIs) to better define the scopes of work in each of the categories

93 RFI responses lead to the identification possible Requests for Proposal (RFPs)

Board authorized the release of 3 RFPs

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. Access to Children's Dental Service ($1.0 million)	5	1
2. Primary Care Services & Social Determinants of Health ($1.4 million)	6	1
3. Access to Adult Dental Service ($1.0 million)	9	1
Total	**20**	**3**

1. Access to Children's Dental Service ($1 million)

Organization	Original Request	Recommended Funding Amount
Healthy Smiles for Kids of Orange County	$1,000,000	$1,000,000
Total	**$1,000,000**	**$1,000,000**

2. Primary Care Services & Social Determinants of Health ($1.4 million)

Organization	Original Request	Recommended Funding Amount
Santa Ana Unified School District	$1,400,000	$1,400,000
Total Awarded	**$1,400,000**	**$1,400,000**

3. Access to Adult Dental Service ($1.0 million)

Organization	Original Request	Recommended Funding Amount
KCS Health Center (Korean Community Services)	$987,600	$1,000,000
Total	**$987,600**	**$1,000,000**

Recommended Board Actions

- Approve the recommended allocations of IGT 5 funds in the amount of $3.4 million for community grants; and,
- Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contracts with the recommended community grantees.

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 February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

Member Health Needs Assessment

Board of Directors Meeting
February 1, 2018

Cheryl Meronk
Director, Strategic Development

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Member Health Needs Assessment

A better study offering deeper insight, leading to a healthier future.

A Better Study

- ➔ More Comprehensive
- ➔ More Engaging
- ➔ More Personal

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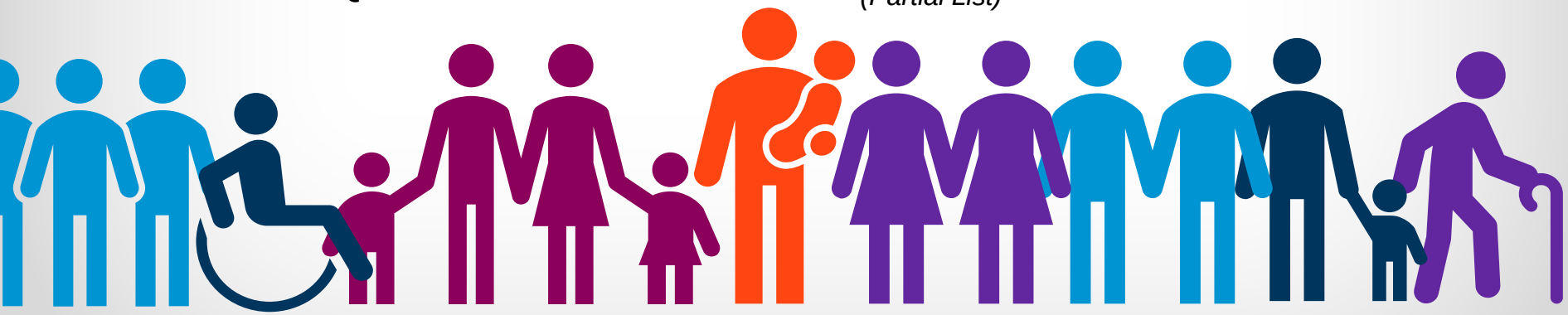
More Comprehensive

- Reached new groups of members whose voices have rarely been heard before
  - Young adults with autism
  - People with disabilities
  - Homeless families with children
  - High school students
  - Working parents
  - New and expectant mothers
  - LGBTQ teens
  - Homeless people in recuperative care
  - Farsi-speaking members of a faith-based group
  - PACE participants
  - Chinese-speaking parents of children with disabilities

(Partial List)



More Comprehensive (Cont.)

- Gathered responses from all geographic areas of Orange County



More Comprehensive (Cont.)

- Probed a broader view of members' lives beyond immediate health care needs
  - Hunger
  - Child care
  - Economic stress
  - Housing status
  - Employment status
  - Physical activity
  - Community engagement
  - Family relationships
  - Mental health
  - Personal safety
  - Domestic violence
  - Alcohol and drug consumption

(Partial List)

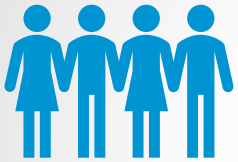


More Comprehensive (Cont.)

- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In the past 12 months, did you have the need to see a mental health specialist?
  - How open are you with your doctor about your sexual orientation?
  - How sensitive are your health care providers in understanding your disability?

(Partial List)

More Engaging: Members



Focus Groups

- 31 face-to-face meetings in the community
- 353 members



Telephone Conversations

- 534 live interviews in members' languages



Mailed Surveys

- Nearly 6,000 surveys returned



Electronic Responses

- More than 250 replied conveniently online

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More Engaging: Member Advocates

- Abrazar Inc.
- Access CA Services
- Alzheimer's OC
- Boys & Girls Club
- The Cambodian Family
- CHOC
- Dayle McIntosh
- La Habra Family Resource Center
- Latino Health Access
- Korean Community Services
- Mercy House
- MOMS Orange County
- OMID
- SeniorServ
- South County Outreach
- State Council on Developmental Disabilities
- Vietnamese Community of OC Inc.

(*Partial List)*

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More Personal

- Met in familiar, comfortable locations at convenient times for our members
  - Apartment complexes
  - Churches
  - Community centers
  - Schools
  - Homeless shelters
  - Recuperative care facilities
  - PACE center
  - Community clinics
  - Restaurant meeting rooms



More Personal (Cont.)

- We spoke their language
  - English
  - Spanish
  - Vietnamese
  - Korean
  - Farsi
  - Chinese
  - Arabic
  - Cambodian
  - Marshallese
  - American Sign Language



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Offering Deeper Insight

- ➔ Barriers to Care
- ➔ Lack of Awareness About Benefits and Resources
- ➔ Negative Social and Environmental Impacts

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Notable Barriers to Care

- Study revealed that members encounter structural and personal barriers to care
  - Structural
    - It can be challenging to get an appointment to see a doctor
    - It takes too long to get an appointment
    - Doctors do not always speak members' languages
    - Interpreter services are not always readily available
    - Doctors lack understanding of members' cultures
  - Personal
    - Members don't think it is necessary to see the doctor
    - Members have personal beliefs that limit treatment
    - Members are concerned about their immigration status
    - Members are concerned someone would find out they sought mental health care

Barriers to Care (Cont.)

Examples

52%

Don’t think it is necessary to see the doctor for a checkup

28%

Takes too long to get an appointment

26%

Concerned someone would find out about mental health needs

41%

Didn’t think it is necessary to see a specialist, even when referred

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Notable Lack of Awareness

- Survey revealed a lack of understanding about available benefits and services
  - 25 percent of members who needed to see a mental health specialist did not pursue treatment
  - 38 percent of members had not seen a dentist in more than a year

- Focus group participants commented frequently about having difficulty regarding certain resources
  - Interpreter services
  - Social services needs
  - Transportation

Lack of Awareness (Cont.)

Examples

40%

Didn’t know who to ask for help with mental health needs

41%

Didn’t see a dentist because of cost (i.e., didn’t know dental care was covered)

25%

Don’t have or know of a dentist

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Negative Social and Environmental Impacts

- Survey revealed significant social and environmental difficulties
  - Lack of well paying jobs and employment opportunities
  - Lack of affordable housing
  - Social isolation due to cultural differences, language barriers or fear of violence
  - Economic insecurity and financial stress
  - Lack of walkable neighborhoods and the high cost of gym programs

Negative Impacts (Cont.)

Examples

32%
Needed help getting food in the past six months

56%
Accessing other public assistance

43%
Needed help to buy basic necessities

29%
Needed help getting transportation

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Negative Impacts (Cont.)

Stakeholder Perspective

> There's a significant issue with improper nutrition. They may not have enough money or the ability to go to the grocery store to buy the right foods. They get what they can, and that's what they eat.
>
> *—Interviewee*

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Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

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Funding

$14.4 Million

Total Available IGT 5 Funds

- **Member Health Needs Assessment results drive funding allocations**

- **Eight Requests for Proposal (RFPs) to expand access to mental health, dental and other care, and outreach/education services**

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RFP 1

Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $5 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category

Adult Mental Health

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RFP 2

Expand Mental Health and Socialization Services for Older Adults

Funding Amount: $500,000

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category

Adult Mental Health

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CalOptima A Public Agency Better. Together.

RFP 3

Expand Access to Mental Health/ Developmental Services for Children 0–5 Years

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Shortage of pediatric mental health professionals
- ✓ Shortage of children's inpatient mental health beds
- ✓ Increase in adolescent depression

Funding Category

Children's Mental Health

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CalOptima A Public Agency Better. Together.

RFP 4

Nutrition Education and Fitness Programs for Children and Their Families

Funding Amount: $1 million

Findings Addressed

- ✓ Healthier food choices can be more expensive, less convenient and less accessible
- ✓ Cultural foods may not be the healthiest options
- ✓ Lack of time and safe places may limit physical activity

Funding Category
Childhood Obesity

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RFP 5

Medi-Cal Benefits Education and Outreach

Funding Amount: $500,000

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits

Funding Category

Supporting the Safety Net

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CalOptima A Public Agency Better. Together.

RFP 6

Expanded Access to Primary Care and Programs Addressing Social Determinants of Health

Funding Amount: $4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Lack of ability to cover basic necessities

Funding Category

Supporting the Safety Net

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RFP 7

Expand Adult Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1.4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Limited dental providers for adults

Funding Category

Supporting the Safety Net

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CalOptima A Public Agency Better. Together.

RFP 8

Expand Access to Children's Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not utilizing covered services
- ✓ Challenging to get an appointment to see a provider

Funding Category

Children's Health

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Moving Forward

- Eight Grant Applications/RFPs
  - Expand access to mental health, dental and other care services
  - Expand access to childhood obesity services regarding nutrition and fitness
  - Support outreach and education regarding social services and covered benefits
- RFPs to be released in March 2018
- Recommended grantees to be presented at June Board meeting

EXECUTIVE SUMMARY
MEMBER HEALTH NEEDS ASSESSMENT

CalOptima
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In summer and fall 2017, more than 6,000 CalOptima members, service providers and community representatives participated in one of the most extensive and inclusive member health needs assessments (MHNA) undertaken by CalOptima in its 20-plus year history. The MHNA provides data critical to ensuring that CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima participates in numerous efforts to assess the health of Orange County's residents and create community-driven plans for improving the health of the Medi-Cal population. Some examples are detailed below.

- The 2013 Orange County Health Profile, produced by the Orange County Health Care Agency, highlighted key health indicators as well as other social, economic and environmental indicators that impact health conditions in groups of people based on economics, race, ethnicity, gender, age and geography.
- The 2016 Orange County Community Indicators Report tracked and analyzed Orange County's health and prosperity on a myriad of issues.
- The 2017 Conditions of Children in Orange County Report offered a comprehensive and detailed summary of how children in Orange County fair in the areas of health, economic well-being, educational achievement, and safe homes and communities.
- CalOptima's Group Needs Assessment, conducted every five years with annual updates in between, identifies members' needs, available health education, cultural and linguistic programs, and gaps in services.

When combined, these assessments provide a broad picture of important health information in Orange County. However, they do not focus specifically on Medi-Cal beneficiaries or on ethnic and linguistic minorities within this population, whose health needs are at the core of CalOptima's mission. For this reason, CalOptima undertook this comprehensive MHNA, summarized on the following pages.

By the Numbers

5,815
Surveys

31
Focus Groups

24
Stakeholder Interviews

21
Provider Surveys

10
Languages

Birth–101
Years of Age

CalOptima's comprehensive MHNA is an innovative collaboration that builds upon existing data-gathering efforts and takes them a step further. The study was designed to be a more comprehensive assessment, using engaging methods that resulted in a much more personal experience for our members and the community. The MHNA captures the unique and specific needs of Medi-Cal beneficiaries from an array of perspectives, including providers, community leaders and, most importantly, the members themselves. As a result, this in-depth study offers actionable recommendations for consideration by the CalOptima Board of Directors and executive leadership.

The MHNA was designed to help CalOptima identify:

1. Unique needs and challenges of specific ethnic communities, including economic, social and environmental stressors, to improve health outcomes

2. Challenges to health care access and how to collaborate with community-based organizations and providers to address these barriers

3. Member awareness of CalOptima services and resources, and effective strategies to increase awareness as well as disseminate information within target populations

4. Ways to leverage outreach efforts by partnering with community-based organizations on strategic programs

Our Partners

To guide the direction of the study, CalOptima established an MHNA Advisory Committee made up of community-based representatives. The committee then engaged CalOptima staff and Harder+Company Community Research (Harder+Company), in partnership with the Social Science Research Center (SSRC) at California State University, Fullerton. A summary of their qualifications to participate in this extensive effort is below.

Harder+Company was founded in 1986 and works with philanthropic, nonprofit and public-sector clients nationwide to reveal new insights about the nature and impact of clients' work. Harder+Company has a deep commitment to lifting the voices of marginalized and underserved communities — and working across sectors to promote lasting change. In addition, Harder+Company offers extensive experience working with health organizations to plan, evaluate and improve services for vulnerable populations, along with deep experience assisting hospitals, health departments and other health agencies on a variety of efforts, including conducting needs assessments, engaging and gathering meaningful input from community members, and using data for program development and implementation.

SSRC was established in 1987 to provide research services to community organizations and research support to university faculty. The center's primary goal is to assist nonprofit and tax-supported agencies and organizations to answer research questions that will lead to improved service delivery and public policy. The SSRC conducts surveys, evaluation research and other applied research activities to meet its clients' information needs. The center conducts multilingual telephone surveys from its 24-station computer-assisted telephone interviewing lab, as well as web-based, mailed and face-to-face surveys. In the past 10 years, SSRC has successfully completed 200 telephone survey projects using a variety of sample designs in diverse areas of focus, such as health care, public safety, education, workforce development and pregnancy prevention.

harder + co | community research

CALIFORNIA STATE UNIVERSITY FULLERTON

Due to strong partnerships with the community, the 2017 MHNA engaged members who may be hard to reach. We are proud that our efforts included:

- Young adults on the autism spectrum
- People with disabilities
- Homeless families and children
- High school students
- Working parents
- New and expectant mothers
- LGBTQ teens
- Farsi-speaking members of faith-based groups
- PACE participants
- Chinese-speaking parents of children with disabilities

More Comprehensive

To represent CalOptima's nearly 800,000 members, an in-depth analysis was performed to uncover their unique needs and challenges. An oversampling was thoughtfully incorporated in the calculation of responses needed to achieve a true statistical representation of the Orange County Medi-Cal population. For the mailed survey, more than 42,000 members were selected within a specific sampling frame that included language, age range and region.

With the oversampling, the aim was to collect 4,000 responses with targets for each subgroup. The final data collection results were far beyond the goal in every subgroup. More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

The assessment gathered responses from all geographic areas of Orange County, across all age groups and 10 languages. Additionally, the assessment reached new groups of members whose voices have rarely been sought out or heard before, such as young adults with autism, people with disabilities and homeless families with children.

Ultimately, the assessment concentrated on the underlying social determinants of health that have been recognized as factors that impact the health of individuals. The MHNA probed a broader view of members' lives beyond immediate health care needs to explore issues related to:

- ☑ Hunger
- ☑ Child care
- ☑ Economic stress
- ☑ Housing status
- ☑ Employment status
- ☑ Physical activity
- ☑ Community engagement
- ☑ Family relationships
- ☑ Mental health
- ☑ Personal safety
- ☑ Domestic violence
- ☑ Alcohol and drug use

More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

More Engaging

The MHNA used a mixed-methods approach to engage members who generally have been underrepresented in previous assessments as well as community stakeholders who work directly with the Medi-Cal population. The data collection effort was extensive, incorporating both qualitative and quantitative methods and going beyond previous processes in Orange County. The mixed-methods approach consisted of the following:

Member Survey

5,815 members completed an in-depth 50-question survey that was available in each of CalOptima's seven threshold languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic. As described further below, three additional languages that are less common in Orange County were also incorporated to ensure the assessment was comprehensive. Most surveys were completed and returned via mail (86 percent), with 9 percent completed via telephone and 5 percent online. Telephone calls were made to reach members who were homeless or more transient and may not have a permanent address. An online survey was offered for members' convenience.

Provider Survey

An online survey of 20 questions was sent to a broad sample of providers in CalOptima's network to seek insight on the challenges that members face. Providers identified what they perceive as the top problems for Medi-Cal members as well as barriers for these members in accessing health care. There were 21 network or physician medical groups that completed the provider survey.

Focus Groups

31 focus groups were conducted with members in partnership with community-based organizations across Orange County. Focus groups allowed for face-to-face conversations with members in comfortable and familiar environments, which helped to foster organic, open-ended discussions where members felt safe to share their thoughts. The discussions were conducted in CalOptima's seven threshold languages, as well as Cambodian, Marshallese and American Sign Language. Focus group conversations covered numerous key topics, including quality of life, community assets, barriers to accessing care, violence, behavioral health, chronic disease, and health practices, such as healthy eating and active living.

Key Stakeholder Interviews

24 leaders from community-based organizations participated in the interviews. Those chosen for the study have direct interactions with Medi-Cal members or serve as advocates for Orange County's vulnerable population. Interviews focused on key health issues facing Medi-Cal members, the provision of culturally competent services, and the social determinants of health, such as economic and environmental factors.

In the spirit of collaboration, individuals and groups in the community came together in a remarkable way to demonstrate their dedication to CalOptima members. Countless hours were spent planning, engaging and meeting with members. For example, in addition to serving as stakeholder interviewees, many of CalOptima's community partners reached out to members to encourage them to respond to the surveys, and they also hosted and recruited members to focus group meetings. Community organizations were invaluable in helping members feel comfortable with the process and in providing another view into members' lives. The engagement of community partners and member advocates was instrumental in the success of the MHNA.

More Personal

The MHNA aimed to give CalOptima members a more personal experience by hosting focus group conversations in familiar locations at convenient times, often evenings and weekends. These settings were intentionally selected based on members' comfort levels. Focus groups were also held at specific times to ensure that members could have their voices heard without having to miss work, school or other obligations. Focus groups were conducted in 10 languages enabling members to respond in their preferred spoken language.

Focus groups were held at:

- Apartment complexes
- Churches
- Community centers
- Schools
- Homeless shelters
- Recuperative care facilities
- PACE center
- Community clinics
- Restaurant meeting rooms

Methods

With a strong focus on engaging a representative sample of CalOptima members, Harder+Company and SSRC developed the sample frame to capture a breadth of perspectives as well as focus on the specific needs of key populations. Although the purpose of the MHNA was to assess the needs of Medi-Cal members in Orange County overall, Harder+Company and SSRC sought to gain a better understanding of the needs of CalOptima's non-English speakers by purposefully oversampling all seven subgroups. The oversampling of members designated as speaking one of the seven threshold languages ensured that CalOptima and community stakeholders can be 95 percent confident that the true population parameters for any particular subgroup will fall between +/- 5 percent of the observed sample estimate.

At more than 5,800 members, the survey response far exceeded the target number of respondents in the sampling frame. The robust response was due to a comprehensive data collection plan that included communication with members and partners in advance of sending the survey, reminder phone calls and multilingual computer-assisted telephone interviewing for members preferring to respond by phone.

Survey data was entered, monitored and quality checked by SSRC before being exported for analysis by Harder+Company. All variables were screened to determine the amount of missing data, and basic frequencies were initially computed for each question by language, region and age. To adjust for the oversampling built into the sampling frame, comprehensive statistical analysis was then completed applying weights calculated by SSRC. Additional analysis included collapsing of questions, construction of scale scores and cross-tabulations.

Exhibit 1: Distribution of Completed Surveys and CalOptima Population by Language, Region and Age

Language	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
English	658	11.3%	55.5%
Spanish	715	12.3%	28.6%
Vietnamese	981	16.9%	10.3%
Korean	940	16.2%	1.4%
Farsi	743	12.8%	1.1%
Arabic	648	11.1%	0.6%
Chinese	731	12.6%	0.5%
Other	399	6.9%	2.0%

Region	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
Central	2,315	39.8%	51.5%
North	1,947	33.5%	32.4%
South	1,538	26.4%	15.1%
Out of County	15	0.3%	1.0%

Age	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
0–18 years old	1,665	28.6%	41.8%
19–64 years old	2,453	42.2%	47.2%
65 or older	1,697	29.2%	10.9%

KEY FINDINGS

Given the scope and depth of the study, the MHNA revealed many key findings, which will all be included in the final, comprehensive report. This Executive Summary shares five **key findings**, including related **bright spots** and **opportunities**. Bright spots are CalOptima and community-based resources that already serve to support health behaviors and outcomes. CalOptima can nurture, leverage and build upon these assets. **Opportunities** are areas that CalOptima and its partners can strengthen to positively impact the health and well-being of members.

KEY FINDING: SOCIAL DETERMINANTS OF HEATLH

Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

Given that Medi-Cal eligibility is income-based, it is not surprising that many CalOptima members struggle with economic insecurity. In fact, 55.7 percent of members receive some form of public benefits (Exhibit 2). Further, in the past six months, more than one-quarter of members indicated they needed help with food (32.4 percent), housing (24 percent), money to buy things they need (43.1 percent) and transportation (28.8 percent) (Exhibit 3). Economic stress and financial insecurity cause members and their families to make tradeoffs, such as living in more dense and overcrowded housing with limited space for play and exercise, buying cheaper but less healthy food, or not going to the doctor despite wanting to.

Exhibit 2: Percent of members who receive public benefits (n=5,117)

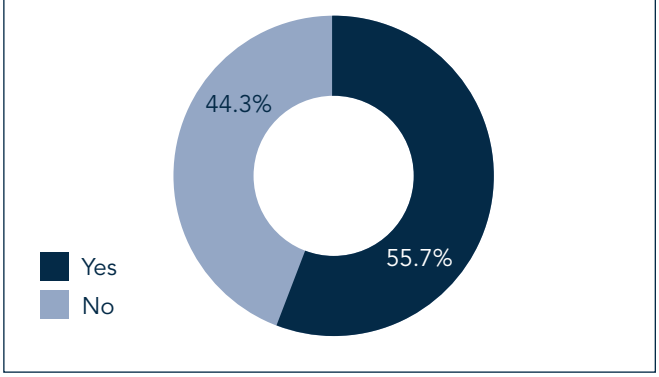
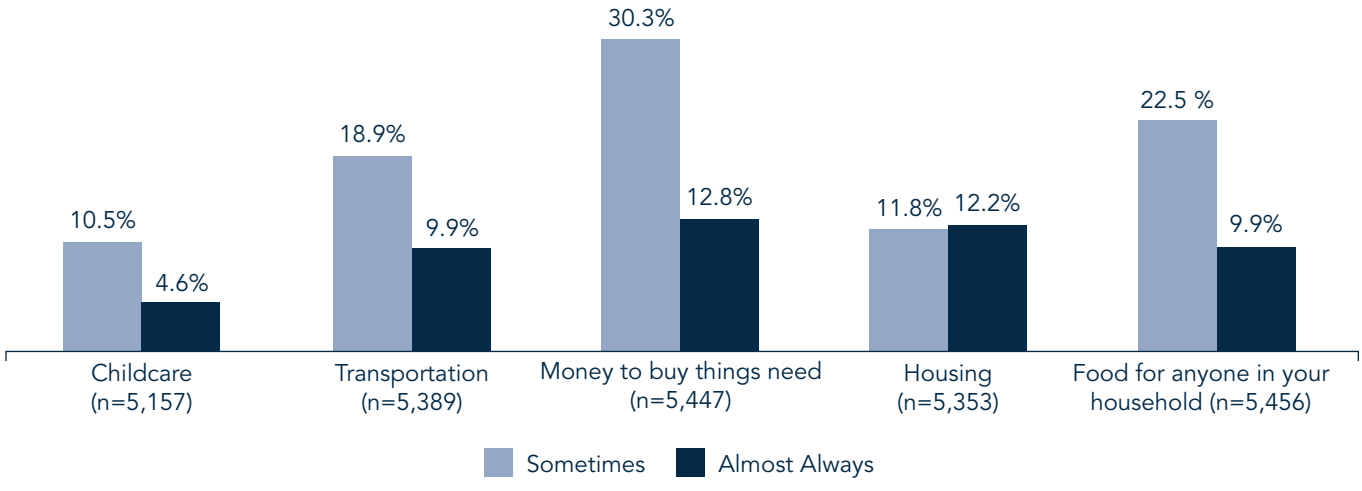
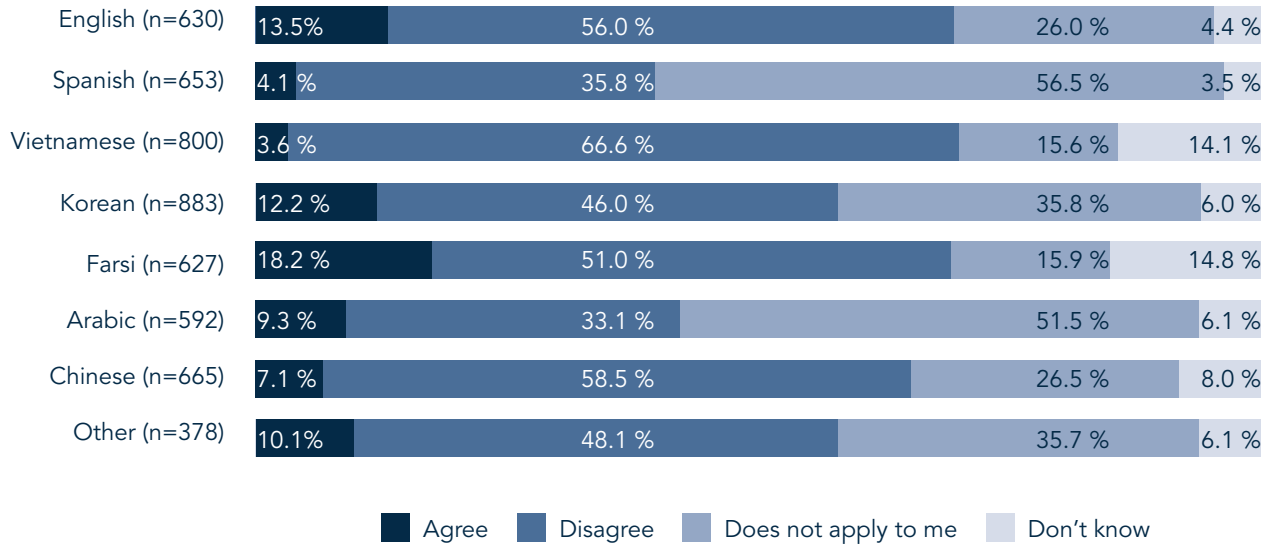


Exhibit 3: Percent of members who needed help with basic needs in the past six months



Social isolation negatively impacts the overall health and well-being of some CalOptima member populations. Social isolation is characterized by a lack of social supports and relationships. It occurs for many reasons, including language barriers, immigration status, age, ability and sexual orientation. In focus groups, members described how feelings of being disconnected from the community can lead to depression, lack of follow-up with health care or service providers, and negative health behaviors. In the survey, 10 percent of all respondents indicated that they felt lonely or isolated. Yet there were higher rates among certain populations, with loneliness and isolation affecting more speakers of English (13.5 percent), Korean (12.2 percent) and Farsi (18.2 percent) (Exhibit 4).

Exhibit 4: Percent of those who reported feeling lonely or isolated by language



Environmental factors also contribute to social isolation and other negative health behaviors, such as lack of physical activity. Focus group participants discussed feeling unsafe in their neighborhoods, which caused them to stay inside or to avoid nearby parks and/or other common spaces.

In addition, lack of affordable housing was a major concern to MHNA respondents, and it resulted in living in overcrowded households, neighborhoods with high crime rates, areas with poor indoor and outdoor air quality, and in the most extreme cases, homelessness.

Bright Spot: CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health a priority, not a lack of knowledge or concern.

Opportunity: CalOptima has already taken steps to strengthen the safety net for members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand this work would positively impact health outcomes in the long run. CalOptima can ensure that providers and community partners understand the social and economic issues that members face and how to adapt health care services accordingly.

KEY FINDING: MENTAL HEALTH

Lack of knowledge and fear of stigma are key barriers to using mental health services.

About 14 percent of members reported needing mental health services in the past year (Exhibit 5). However, local and national data suggest that the need for mental health services is likely underreported and underrecognized. Among those reporting a need, nearly 25 percent did not see a mental health specialist (Exhibit 6). Members did not seek mental health services for several reasons (Exhibit 7), including not knowing who to call or how to ask for help making an appointment (39.8 percent), not feeling comfortable talking about personal problems (37.5 percent) or concern that someone would find out they had a problem (26.1 percent). These factors, along with data gathered from key stakeholder interviews and focus groups, reflect a fear of stigma associated with seeking mental health services.

Exhibit 5: Percent of members who indicated they needed to see a mental health specialist (n=5,723)

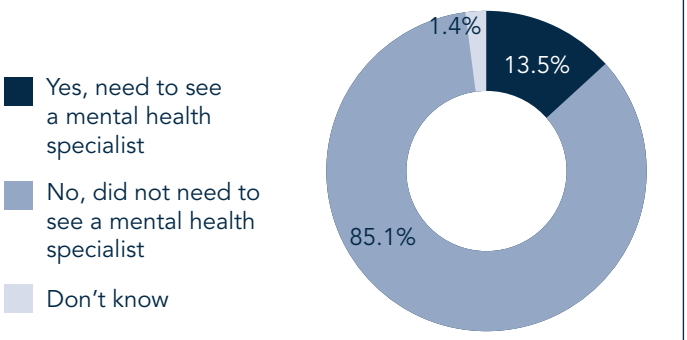
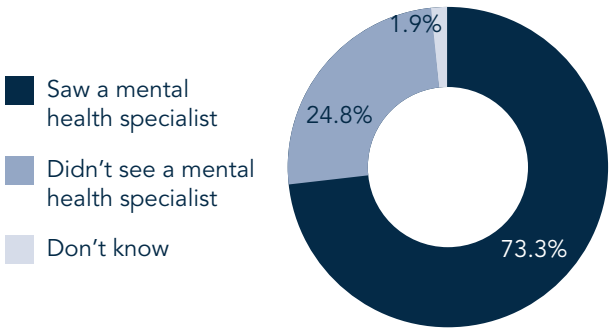
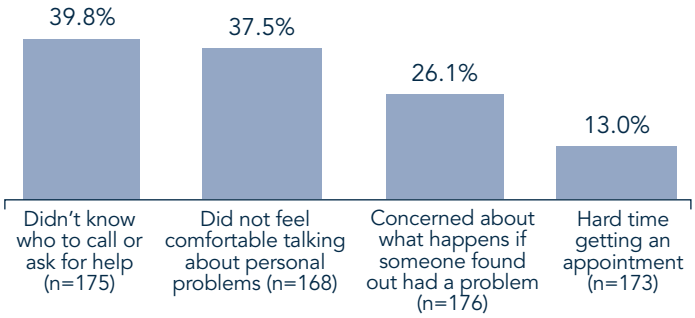


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



Fear of stigma is more prevalent among certain language groups. For example, Chinese-speaking members were more likely to indicate discomfort talking about personal problems and concern about what others might think if they found out about a mental illness than other language groups, followed by Korean-, Vietnamese- and English-speaking members. Conversations with community members and service providers offered cultural context for these findings as many stakeholders described prevalent feelings of shyness, avoidance and shame around discussing mental health issues, let alone seeking care.

Exhibit 7: Reasons why members (who needed to see a mental health specialist but) didn't get services



Bright Spot: CalOptima provides access to mental health services, which meets a clearly established need. Although members needing mental health services do not always connect with providers, many do not do so because of a lack of knowledge, an issue that can be addressed through strengthened connections with existing systems.

Opportunity: Although mental health services are covered by CalOptima, fear of stigma may prevent members from seeking services. This presents an opportunity for CalOptima to continue to provide culturally relevant education around mental health to improve understanding of available services and to address fear of stigma many people face. Community partners with deep knowledge of specific cultural communities are eager to offer support that would increase the use of mental health services.

KEY FINDING: PRIMARY CARE

Most members are connected to primary care, but barriers can make it challenging to receive timely care.

The majority of CalOptima members indicated that they are connected to at least one primary care doctor (82.6 percent), and most go to a doctor's office (69.2 percent) or clinic/health center (18.1 percent) when they need medical attention (Exhibits 8 and 9). However, navigating the health care system can be challenging, and significant barriers make it difficult for people to seek or follow through with care when needed.

Exhibit 8: Percent who report at least one person as their doctor (n=5,749)

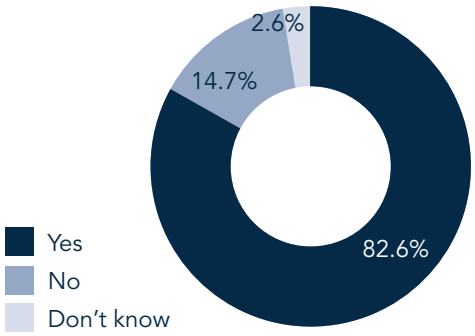
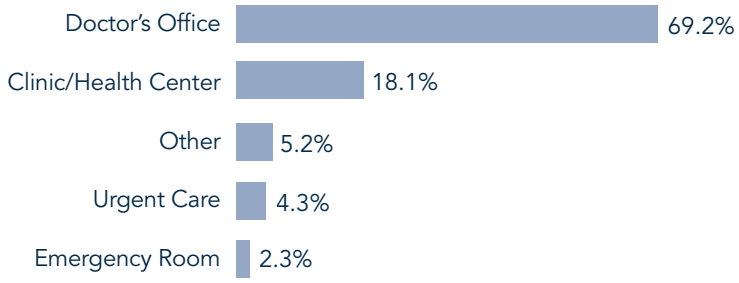


Exhibit 9: Where respondents go to see their doctor (n=5,743)

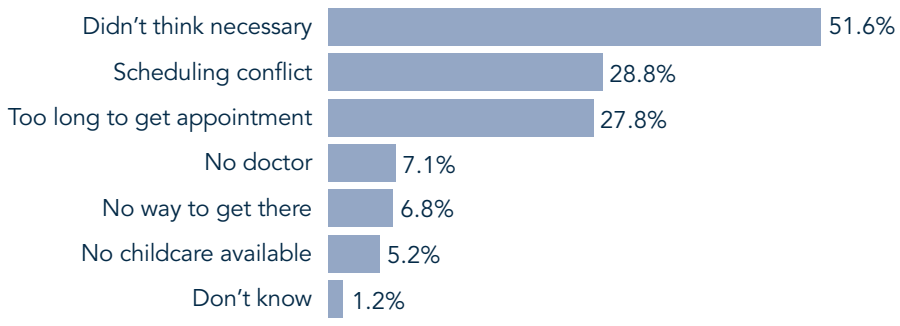


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited hours of operation and inefficiency of public transportation, can make it difficult for people to receive care when needed. When asked why they don't make an appointment to see a doctor, 27.8 percent of CalOptima members indicated that it takes too long to get an appointment while 51.6 percent of members did not think it was necessary to make an appointment (Exhibit 10).

Bright Spot: CalOptima members have access to more than 1,500 primary care providers and 6,200 specialists, as well as 14 different health networks. And staff members are dedicated to continually engaging and educating these providers and networks to ensure they are ready to deliver the care needed by members.

Opportunity: The challenge of maintaining a robust provider network never goes away, and CalOptima must carefully monitor members' access to care. The provider community may be ready to embrace innovations that enhance access, such as extended hours, weekend operations or telemedicine visits, to expand the options for members.

Exhibit 10: Reasons why members don't make an appointment to see doctor (n=4,598)[1]



KEY FINDING: PROVIDER ACCESS

Members are culturally diverse and want providers who both speak their language and understand their culture.

CalOptima members hail from around the globe, reflecting the rich diversity of Orange County's population. In total, 40.3 percent of respondents were born outside of the U.S. and 23.6 percent indicated that they don't speak English well (Exhibits 11 and 12). Among non-English speakers, more than 50 percent were born outside of the United States and many are still acculturating to life in the U.S. This presents challenges when finding a well-paying and fulfilling job, safe and affordable housing, and healthy and familiar food. It also affects the ways members interact with the health care system. In fact, those born outside of the U.S. were significantly less likely to have a doctor and more likely to report feeling lonely or isolated.

Exhibit 11: How well members speak English (n=5,549)

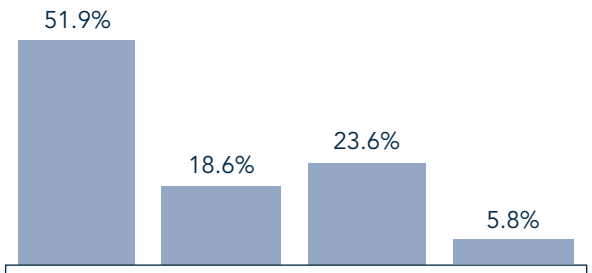
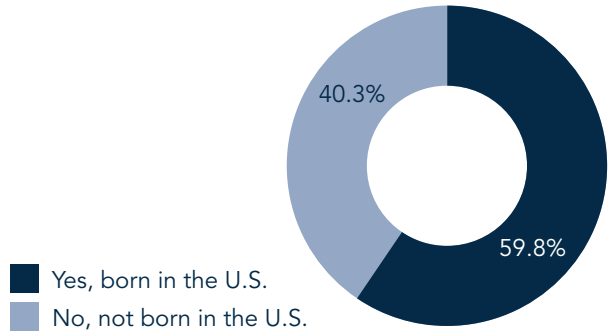


Exhibit 12: Percent of members who were born in the United States (n=5,599)



Further, they report having to adapt to new ways of receiving medical care. Some focus group participants shared that they did not understand why they must wait so long to see a doctor, as it is not this way in their country of origin. Others shared that cultural beliefs and practices made them uncomfortable and often unwilling to see a physician of the opposite gender. In addition, members and key stakeholders indicated that it can be challenging to seek medical care from providers who do not speak members' preferred language, which leads to issues with communication and comfort level. Although many stakeholders highlighted the availability of translation or interpretation services, such services do not always meet members' needs, especially when limited by short appointment times and when sharing sensitive information.

Bright Spot: CalOptima provides services and resources to members in seven languages[2] and can connect members to translation and interpretation services in any language when needed. Members appreciate that CalOptima recognizes the importance of providing care in familiar languages, and they also highly value providers who are sensitive to the cultural norms and practices of their homeland.

Opportunity: CalOptima has an opportunity to build its existing resources and deepen cultural competence of providers and services. CalOptima can engage partners in culturally focused community-based organizations to tailor and implement trainings for providers around specific populations. Trainings can build language and sensitivity skills and increase knowledge in areas such as ethnopharmacology (variations in medication responses in diverse ethnic populations). This can strengthen the workforce and improve member/provider interactions overall.

KEY FINDING: DENTAL CARE

Many members are not accessing dental care and are often unsure about what dental services are covered.

The gap in dental health care is striking and pronounced; 38.2 percent of members indicated they had not seen a dentist within the past 12 months (Exhibit 13). Among those individuals, 41 percent cited cost as the main reason they did not see a dentist (Exhibit 14). Members expressed confusion about dental care benefits available to them via Medi-Cal/Denti-Cal, and they said they would be more likely to seek out a dentist if they knew some of their visits were covered.

Bright Spot: Members in all CalOptima programs are eligible for routine dental care through Denti-Cal, and members in OneCare and OneCare Connect have access to supplemental dental care as well. Better yet, for 2018, California restored additional Denti-Cal benefits, expanding the covered services even further. The challenge is ensuring that members know about these benefits and then actually obtain the services.

Opportunity: To boost the number of members receiving dental care, CalOptima will have to first raise awareness about the availability of services and correct misperceptions that dental care comes at a cost. Further, to remove barriers to care and expand access, the community may embrace the use of alternative providers, such as mobile dental clinics, or the option of co-located dental and medical services.

Exhibit 13: When members last saw a dentist (n=5,685)

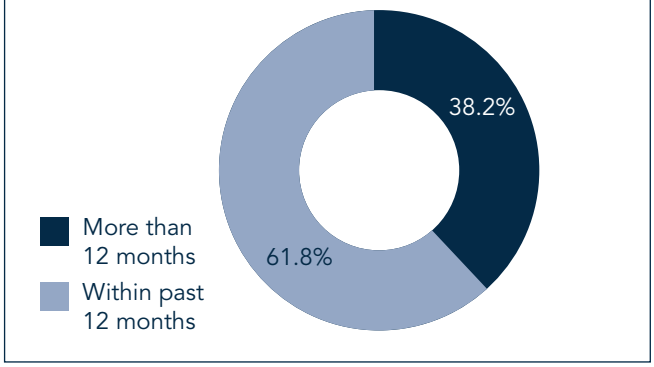
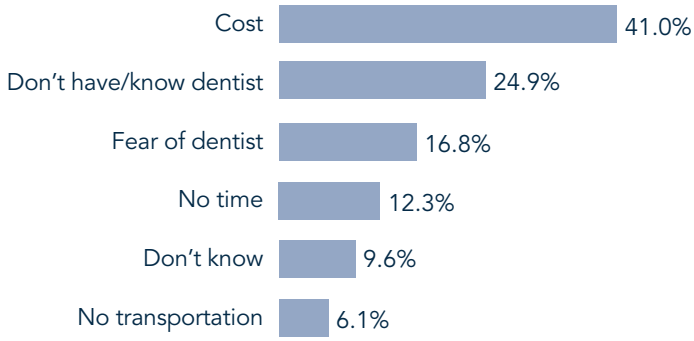


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3][4]



Endnotes

[1] Members could choose multiple answers; thus, the total does not equal 100 percent.

[2] CalOptima provides bilingual staff, interpreter services, health education and enrollment materials in seven languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.

[3] Members could choose multiple answers; thus, the total does not equal 100 percent.

[4] Only reported those who have not seen a dentist within the past 12 months.

January 2018

CalOptima Member Survey Analysis:

Unweighted Estimates by Language, Region, and Age

DRAFT

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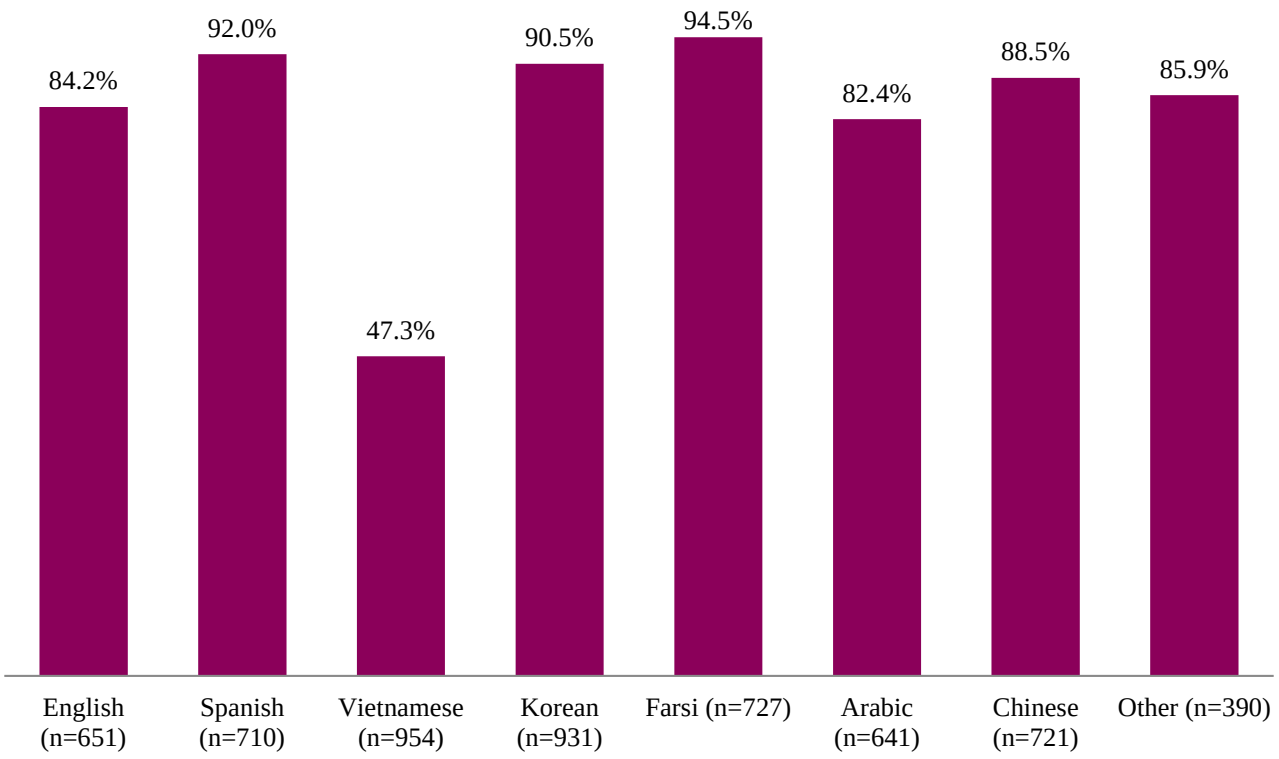
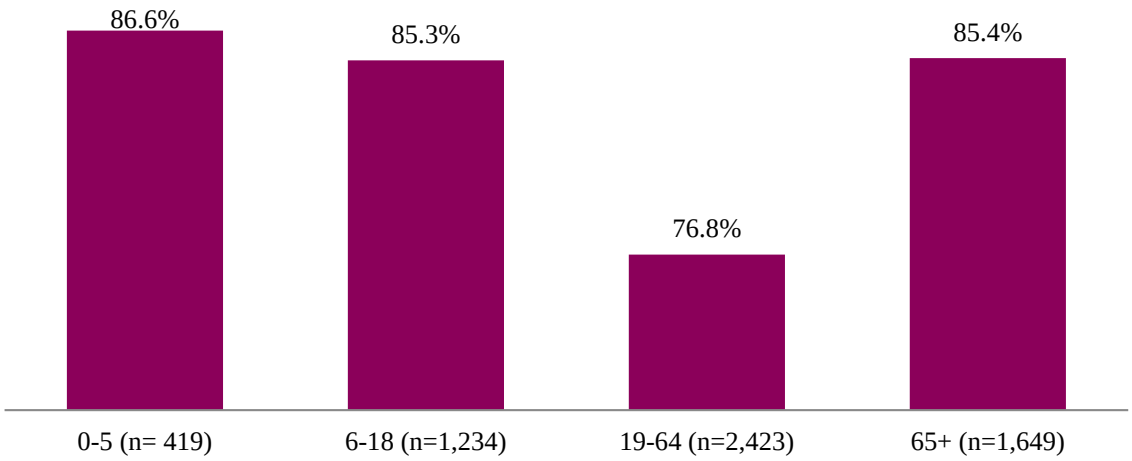
Navigating the Healthcare System

Exhibit 1. Percent who report at least one person as their doctor[1]

CalOptima language:



Age Group:



[1] An issue was identified with the Vietnamese translation of this question. Therefore, results likely misrepresent percentage of Vietnamese members who have a doctor.

Region:

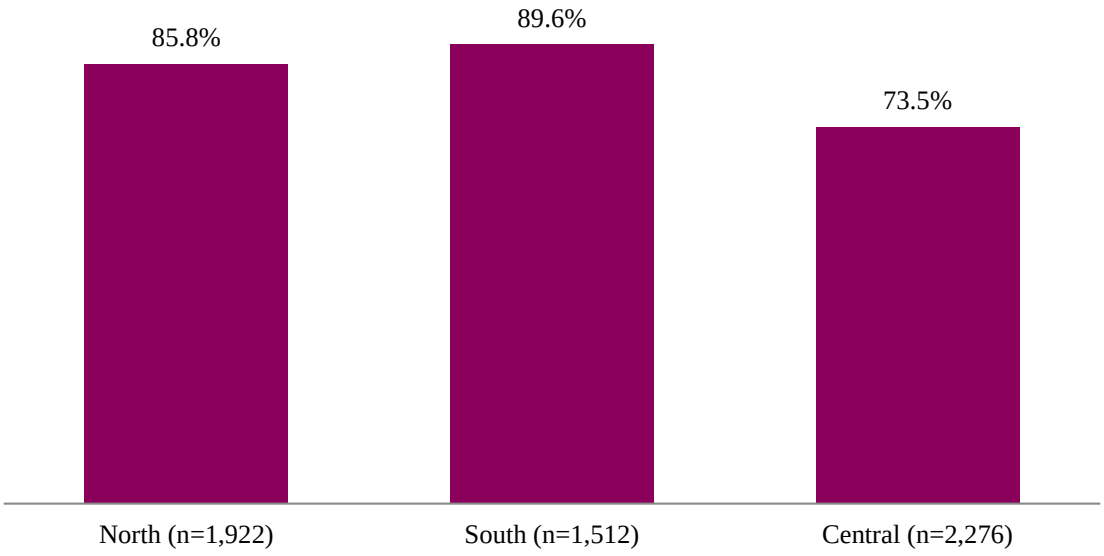


Exhibit 2. Where respondents go to see their doctor

CalOptima language:

CalOptima Language	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
English	71.8%	11.9%	2.0%	6.6%	0.5%	6.4%	0.8%	653
Spanish	59.7%	32.3%	3.4%	1.0%	0.3%	3.1%	0.1%	699
Vietnamese	86.3%	12.0%	0.1%	0.2%	0.0%	1.0%	0.3%	965
Korean	87.8%	4.3%	0.9%	1.1%	0.7%	4.1%	1.2%	938
Farsi	84.0%	6.5%	3.0%	0.8%	0.1%	5.0%	0.5%	737
Arabic	65.3%	15.8%	4.6%	5.4%	0.3%	8.0%	0.5%	625
Chinese	77.2%	11.4%	0.3%	0.8%	0.4%	6.6%	3.3%	727
Other	72.2%	12.6%	1.5%	3.0%	0.0%	9.6%	1.0%	396

Age Category:

CalOptima Age Category	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	68.4%	19.1%	1.9%	2.7%	0.2%	7.2%	0.5%	414
6-18 (Children)	73.0%	16.5%	1.6%	3.0%	0.4%	4.4%	1.0%	1,224
19-64 (Adults/MCE)	73.1%	14.2%	2.6%	2.7%	0.5%	5.5%	1.4%	2,425
65+ (Older Adults)	87.5%	6.8%	0.8%	0.4%	0.1%	4.1%	0.4%	1,677

Region:

CalOptima Region	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
North	74.4%	13.8%	1.7%	3.4%	0.4%	5.4%	1.0%	1,920
South	80.4%	7.9%	2.0%	1.4%	0.5%	6.4%	1.4%	1,521
Central	76.8%	15.5%	1.8%	1.4%	0.2%	3.6%	0.6%	2,284

Exhibit 3. Reasons why members go somewhere other than their doctor when they need medical attention

CalOptima language:

CalOptima Language	I don't have a doctor	It is easier for me to get to the emergency room or urgent care than my doctor's office	It's hard to get an appointment with my doctor	Other	Don't know	n
	%	%	%	%	%	
English	7.4%	26.5%	21.4%	40.7%	4.0%	570
Spanish	7.5%	22.2%	20.1%	37.9%	12.4%	523
Vietnamese	3.1%	31.8%	16.8%	46.2%	2.1%	584
Korean	11.5%	22.7%	27.8%	37.6%	0.4%	687
Farsi	3.1%	15.4%	22.7%	58.8%	0.0%	422
Arabic	5.2%	40.6%	25.5%	28.0%	0.7%	554
Chinese	9.1%	26.8%	14.6%	47.9%	1.6%	549
Other	6.0%	24.9%	16.7%	50.8%	1.6%	317

Age Category:

Age Category	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
0-5 (Children)	4.5%	34.4%	25.4%	29.3%	6.5%	355
6-18 (Children)	5.2%	27.7%	24.0%	36.2%	6.9%	986
19-64 (Adults/MCE)	9.2%	26.0%	23.7%	39.9%	1.3%	1,789
65+ (Older Adults)	4.5%	34.4%	25.4%	29.3%	6.5%	1,076

Region:

Region	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
North	7.4%	27.1%	25.2%	38.4%	1.9%	1,501
South	6.7%	23.1%	20.5%	47.2%	2.5%	1,052
Central	6.3%	28.9%	17.6%	43.2%	4.0%	1,639

Exhibit 4. When do members make an appointment to see doctor[2]

CalOptima Language:

CalOptima Language	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
English	75.8%	77.2%	51.8%	1.1%	4.2%	650
Spanish	77.7%	76.2%	36.9%	0.8%	4.5%	713
Vietnamese	76.0%	74.7%	39.7%	0.1%	1.7%	973
Korean	81.3%	75.2%	47.4%	0.4%	0.6%	938
Farsi	87.4%	80.0%	65.1%	1.8%	3.7%	736
Arabic	82.5%	40.4%	30.9%	0.5%	1.4%	644
Chinese	80.3%	73.6%	48.6%	1.5%	1.2%	727
Other	70.1%	82.0%	51.1%	1.5%	4.6%	395

Age Category:

Age Category	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
0-5 (Children)	86.4%	76.9%	41.9%	0.7%	1.2%	420
6-18 (Children)	81.8%	73.2%	39.9%	0.5%	2.2%	1,236
19-64 (Adults/MCE)	78.0%	67.9%	47.3%	1.1%	2.3%	2,433
65+ (Older Adults)	77.8%	77.4%	50.0%	0.9%	3.4%	1,687

[2] **Members were allowed to choose multiple answers; thus, the total does not equal 100%.**

Region:

Region	When Sick	Check-Up	Specialist Needed	Don't Know	Other	n
	%	%	%	%	%	
North	78.2%	70.5%	43.6%	0.9%	2.3%	1,938
South	83.3%	75.9%	55.9%	1.3%	2.8%	1,527
Central	77.7%	72.0%	41.8%	0.5%	2.5%	2,296

Exhibit 5. Reasons why members don't make an appointment to see doctor[3]

CalOptima language:

CalOptima Language	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
English	7.8%	6.7%	28.0%	27.6%	5.2%	54.0%	1.8%	554
Spanish	6.3%	6.5%	20.8%	27.4%	5.2%	53.2%	0.8%	504
Vietnamese	2.3.%	7.0%	50.9%	24.8%	4.1%	42.8%	0.0%	725
Korean	11.7%	4.1%	48.4%	39.7%	3.8%	31.5%	0.0%	677
Farsi	5.7%	19.5%	24.9%	45.1%	6.9%	33.3%	0.0%	406
Arabic	2.7%	7.0%	28.2%	42.6%	2.1%	37.1%	0.0%	561
Chinese	7.2%	9.6%	29.8%	24.8%	2.2%	51.0%	0.9%	541
Other	4.1%	8.8%	25.0%	29.1%	1.7%	56.8%	0.0%	296

[3] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Age Category:

Age Category	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	4.6%	6.5%	32.8%	35.9%	10.5%	43.7%	0.0%	323
6-18 (Children)	4.8%	4.5%	38.2%	32.8%	3.9%	43.4%	0.1%	990
19-64 (Adults /MCE)	7.8%	7.4%	36.3%	34.5%	4.2%	39.5%	0.8%	1,933
65+ (Older Adults)	4.5%	13.3%	26.1%	26.9%	1.3%	53.2%	0.3%	1,018

Region:

Region	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%			
North	7.6%	7.7%	36.3%	35.0%	3.3%	40.5%	0.3%	1,521
South	6.3%	10.5%	27.5%	35.8%	4.8%	45.7%	0.6%	1,019
Central	4.6%	6.9%	35.9%	28.1%	4.0%	46.1%	0.5%	1,712

Exhibit 6. When do members make an appointment to see a specialist[4]

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
English	76.0%	26.5%	63.5%	638
Spanish	71.9%	30.5%	60.7%	679
Vietnamese	70.3%	24.4%	56.7%	949
Korean	69.1%	27.1%	45.2%	877
Farsi	78.6%	31.4%	55.7%	688
Arabic	68.9%	16.3%	42.5%	631
Chinese	66.0%	35.6%	45.4%	694
Other	79.2%	26.8%	59.9%	384

Age Category:

Age Category	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
0-5 (Children)	71.1%	28.4%	53.8%	394
6-18 (Children)	67.7%	25.7%	52.6%	1,172
19-64 (Adults/MCE)	71.5%	25.2%	54.5%	2,328
65+ (Older Adults)	75.7%	31.3%	51.7%	1,646

[4] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

Region:

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
North	69.3%	27.7%	50.6%	1,857
South	74.3%	28.3%	52.9%	1,453
Central	72.6%	26.6%	55.5%	2,216

Exhibit 7. Reasons why members don't make an appointment to see specialist[5]

CalOptima Language:

CalOptima Language	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
English	19.5%	8.0%	20.4%	27.0%	41.1%	548
Spanish	7.9%	5.5%	12.0%	20.2%	46.4%	560
Vietnamese	11.3%	9.3%	37.8%	30.7%	33.4%	724
Korean	14.2%	12.5%	32.6%	41.5%	27.6%	696
Farsi	13.9%	14.3%	15.2%	37.6%	24.5%	474
Arabic	9.9%	6.9%	21.5%	47.1%	25.6%	577
Chinese	11.9%	14.6%	17.6%	25.4%	42.6%	556
Other	15.6%	12.6%	16.5%	27.2%	39.2%	334

Age Category:

Age Category	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
0-5 (Children)	10.8%	8.1%	22.8%	33.5%	41.0%	334
6-18 (Children)	12.1%	7.9%	27.2%	32.1%	35.9%	1,019
19-64 (Adults/MCE)	13.7%	9.8%	24.9%	35.5%	31.6%	1,953
65+ (Older Adults)	12.6%	13.8%	16.3%	27.6%	37.0%	1,163

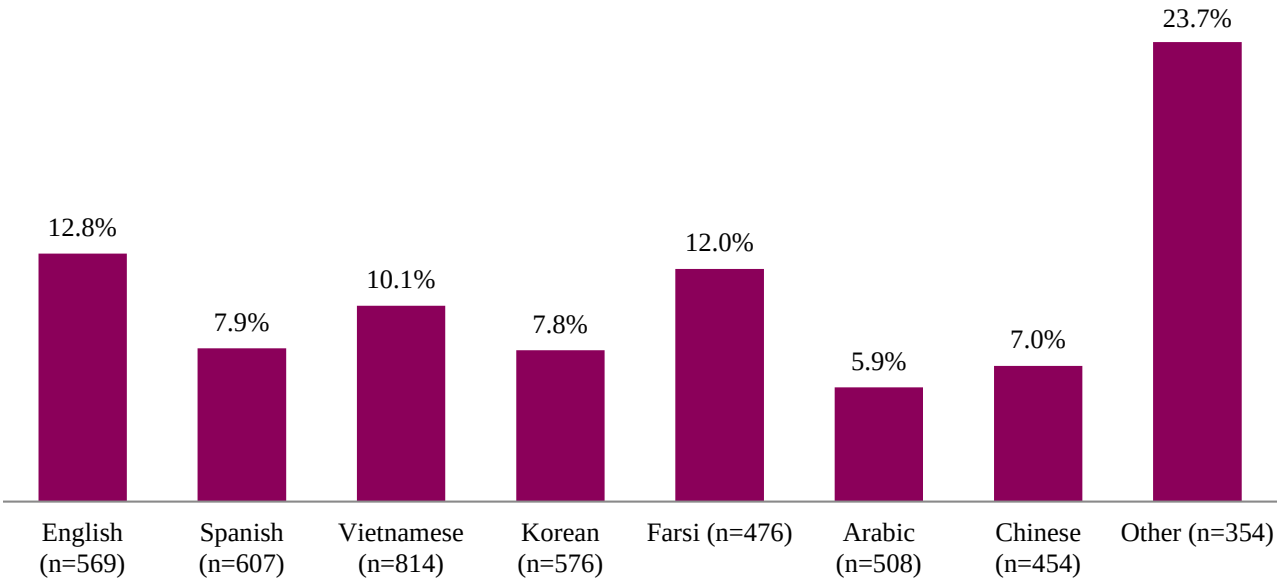
[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Region:

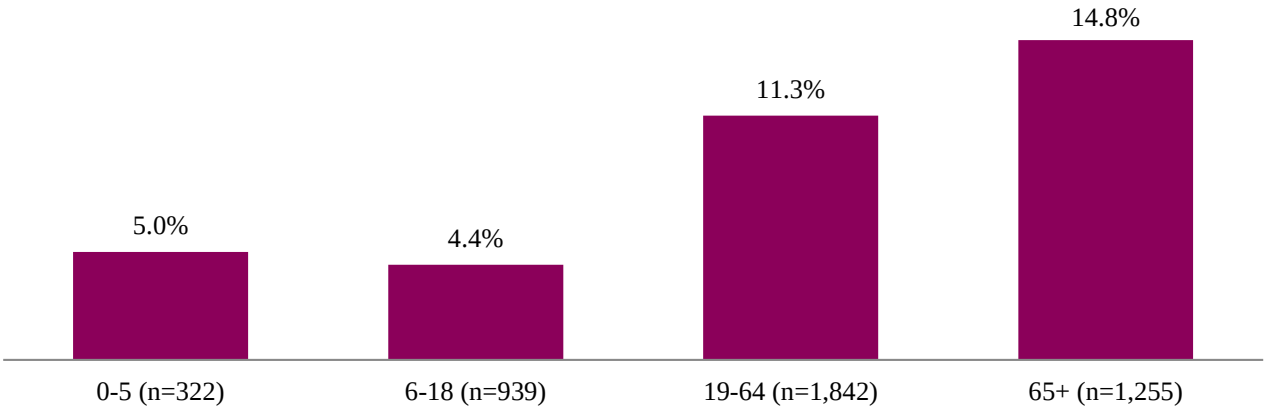
Region	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
North	14.0%	11.3%	24.8%	35.9%	31.1%	1,567
South	13..6%	11.3%	17.5%	33.6%	35.9%	1,097
Central	11.4%	8.8%	24.9%	28.9%	37.2%	1,792

Exhibit 8. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor

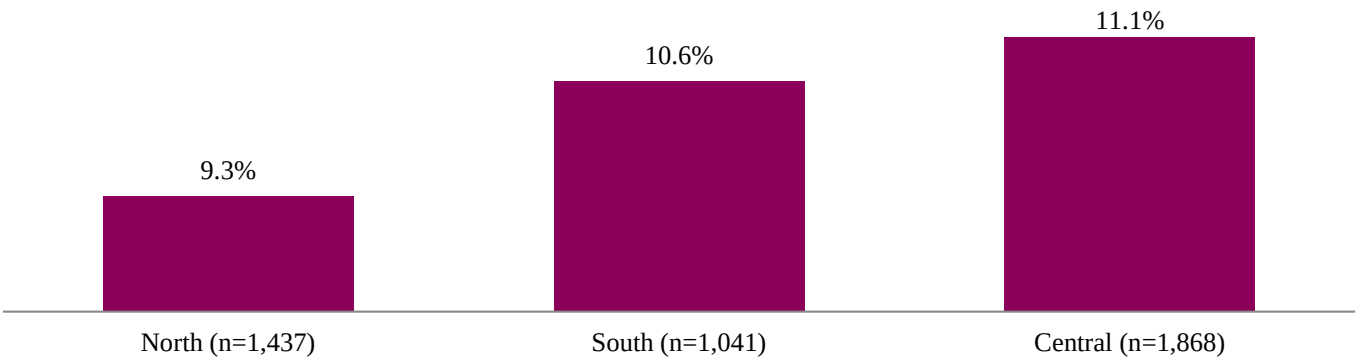
CalOptima language:



Age Category:



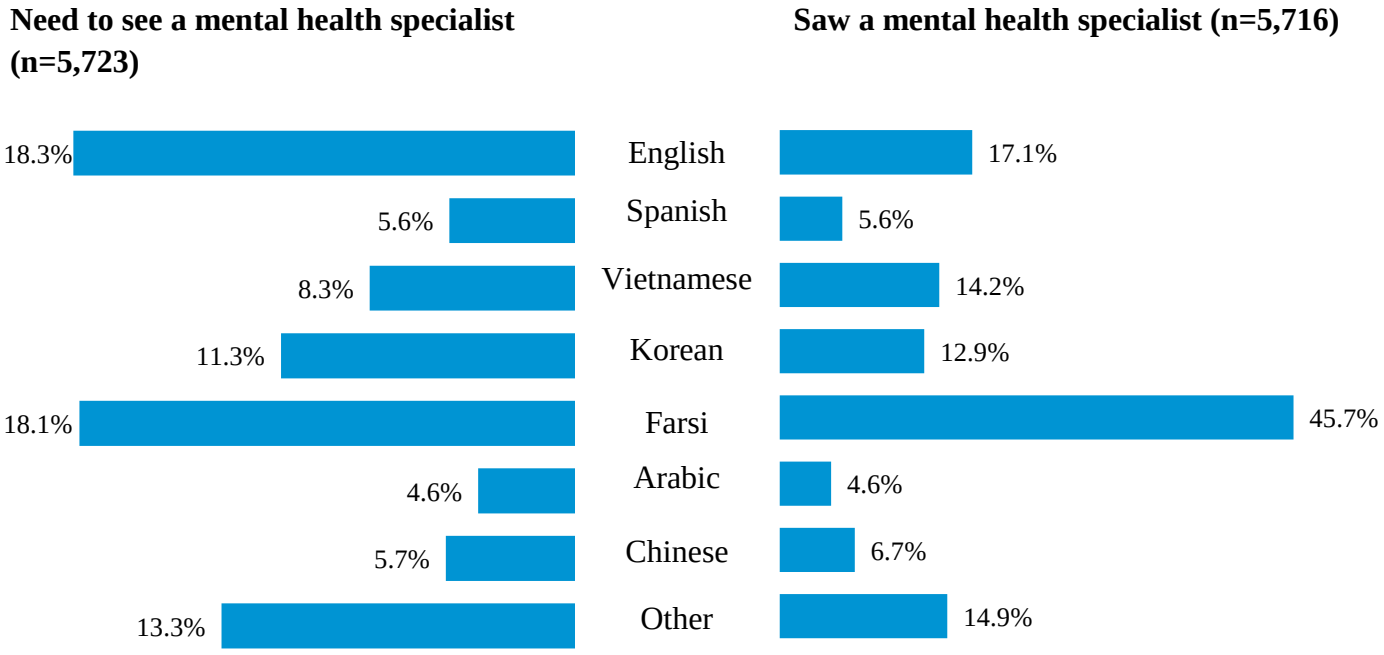
Region:



Social and Emotional Well-Being

Exhibit 9. Members who needed to see compared to those who saw a mental health specialist in the last 12 months[6]

CalOptima Language:

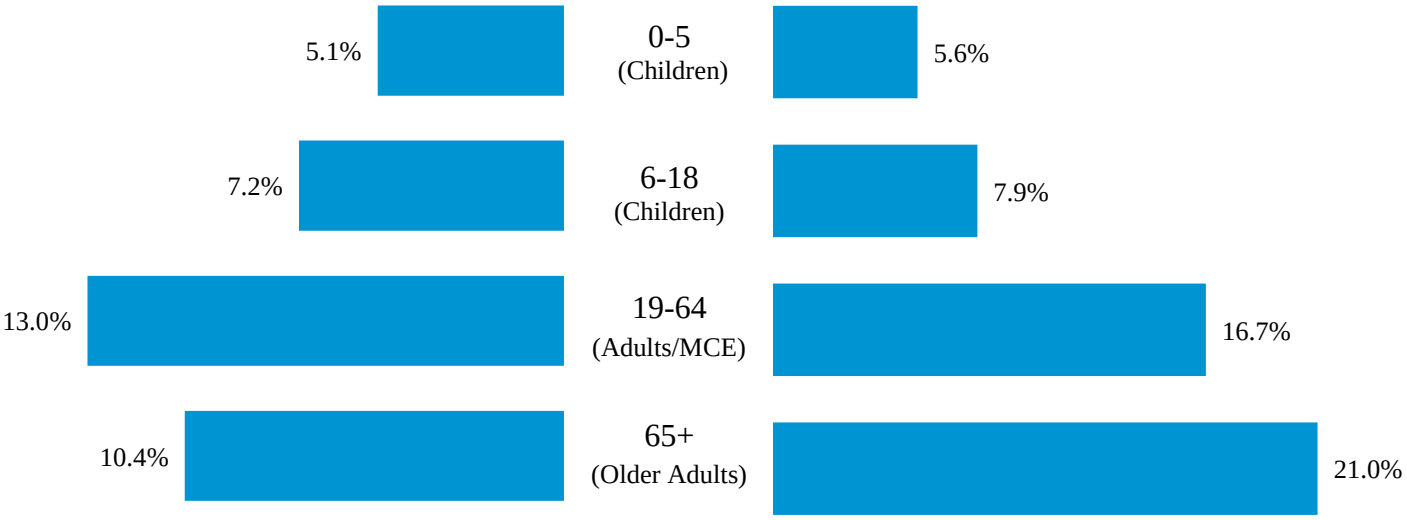


[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

Age Category:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)



Region:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)

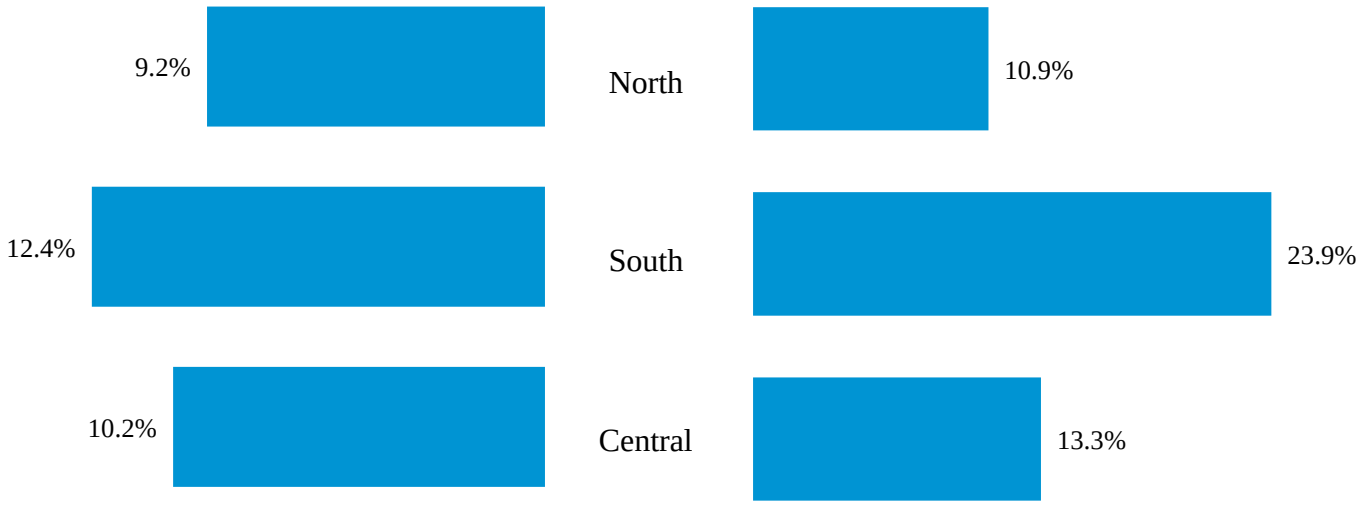
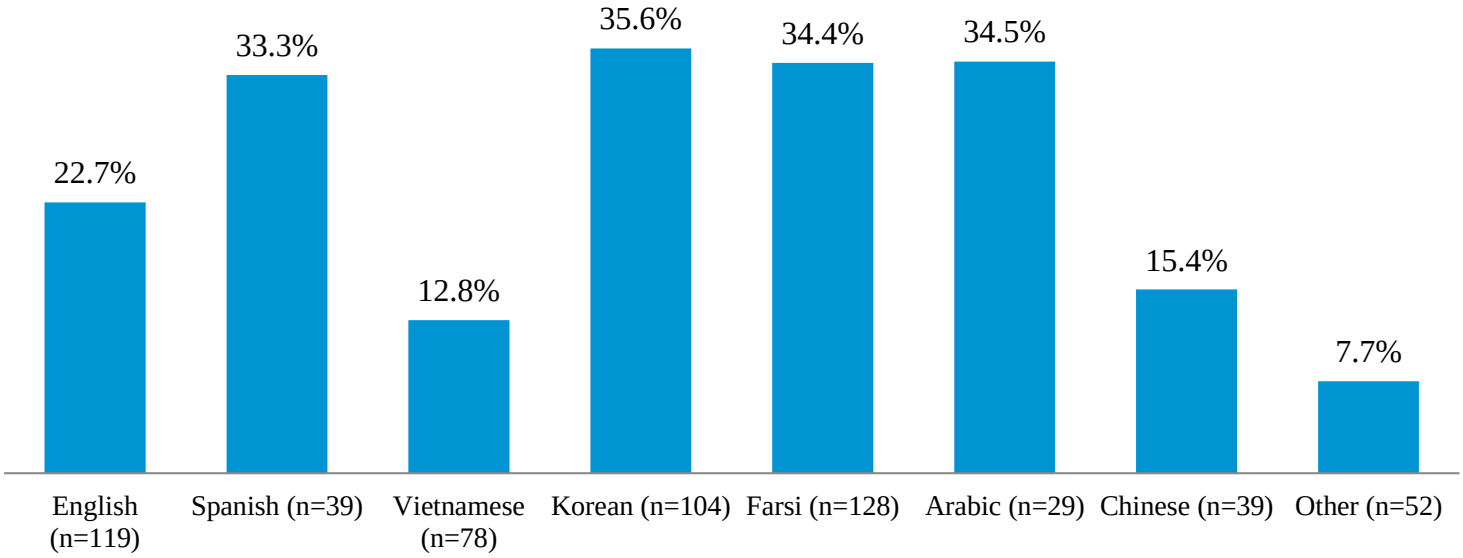
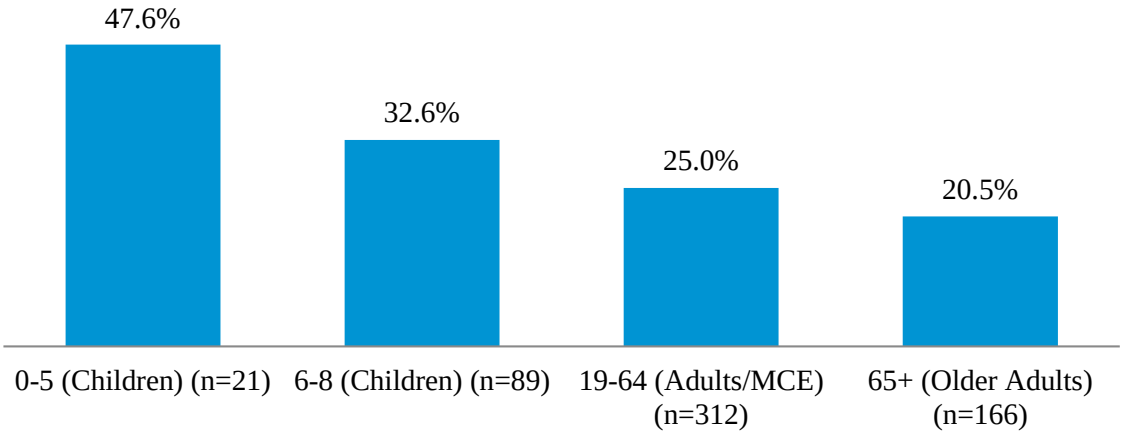


Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist

CalOptima Language:



Age Category:



Region:

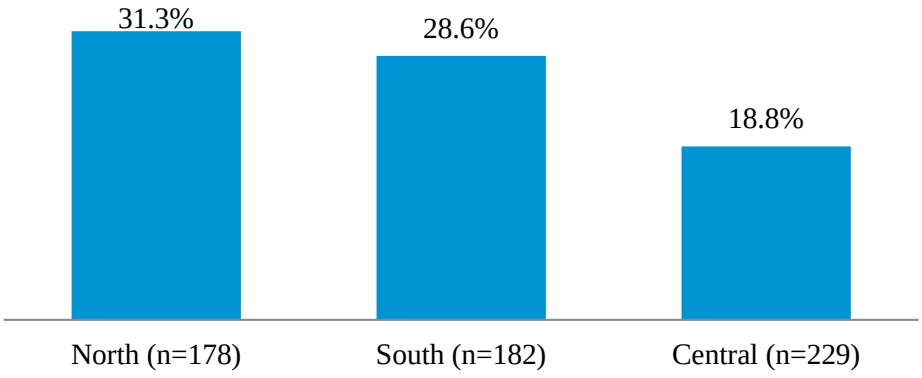
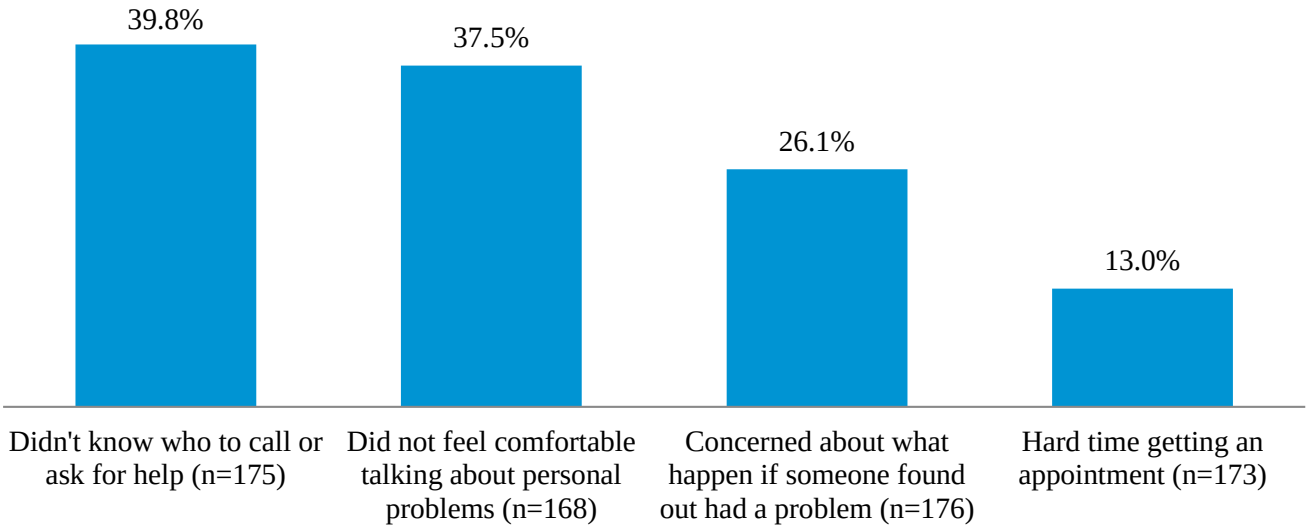


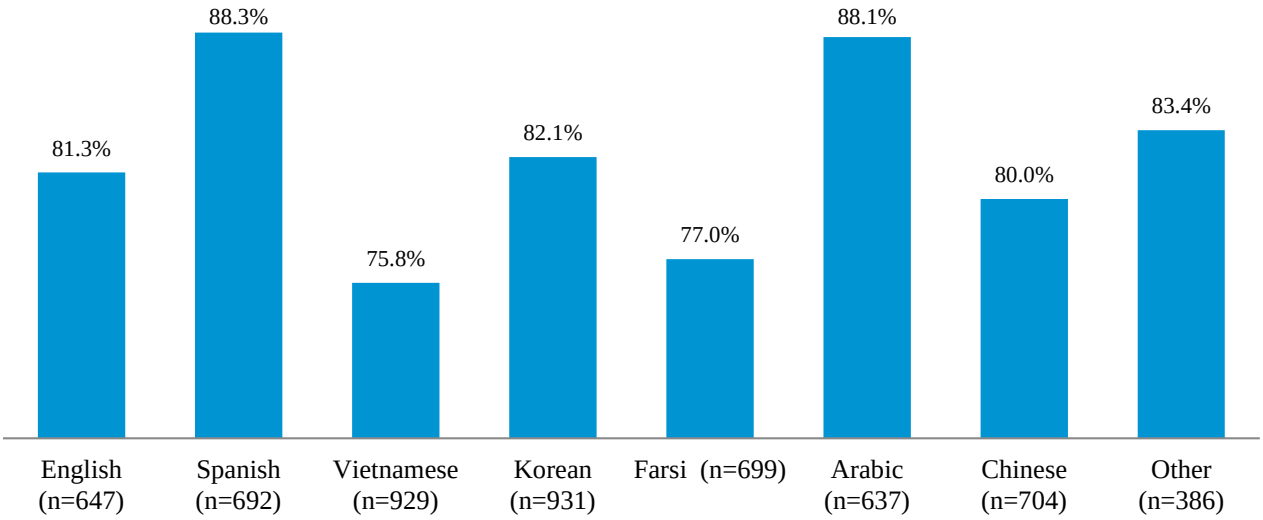
Exhibit 11. Reasons why members didn't see mental health specialist[7]



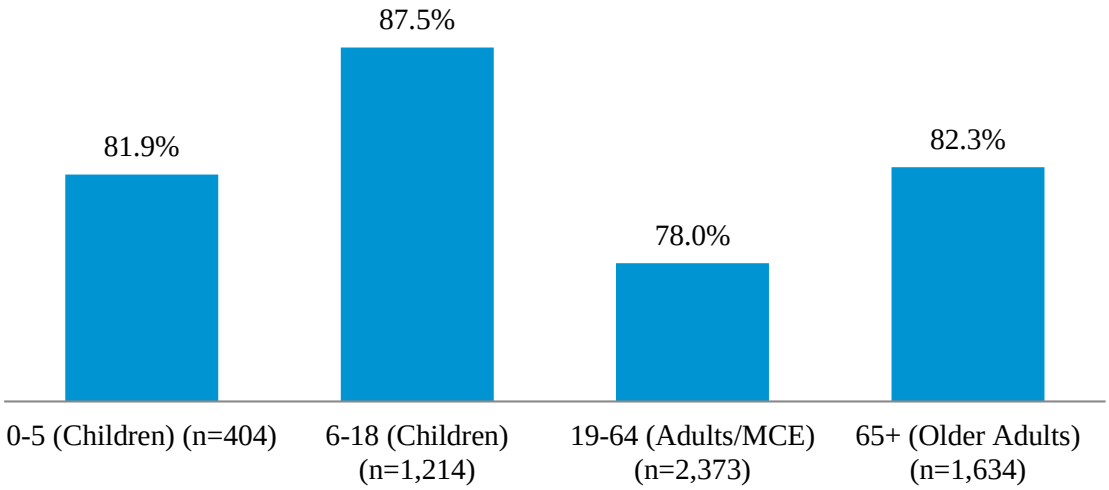
[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

Exhibit 12. Percent of members who can share their worries with family members

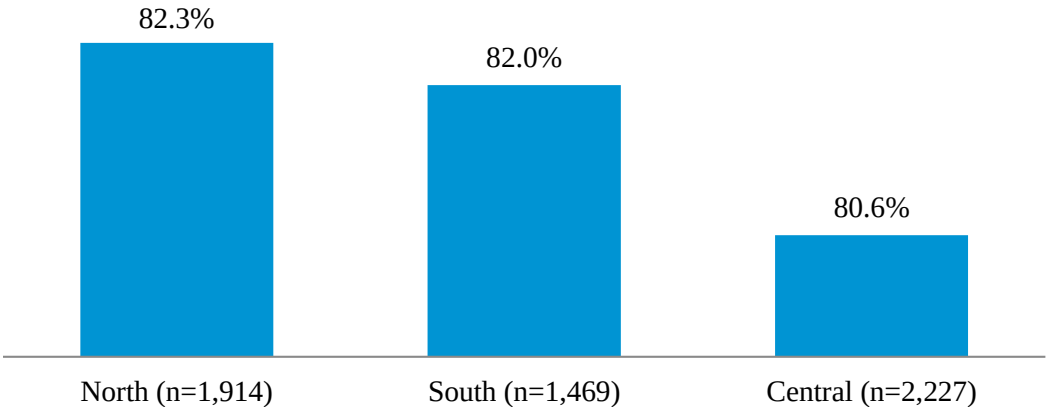
CalOptima language:



Age Category:



Region:

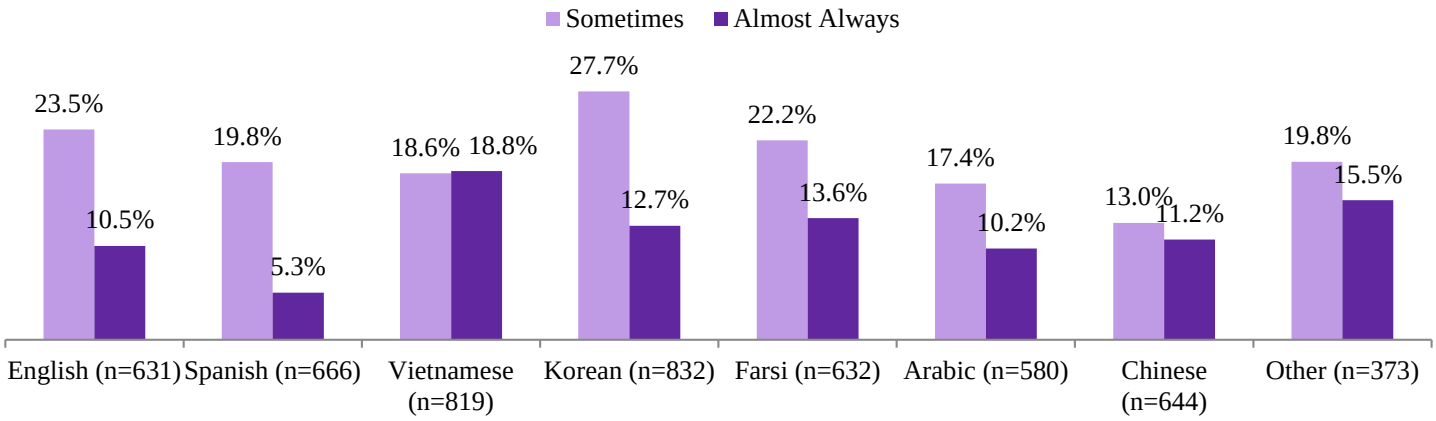


Social Determinants of Health

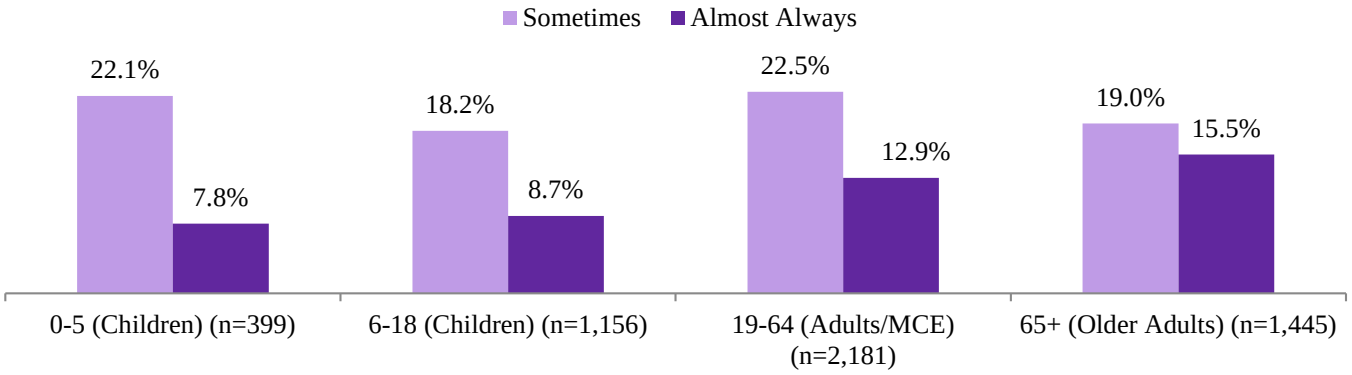
Exhibit 13. Needed help with the following in the past 6 months:

Food for anyone in your household:

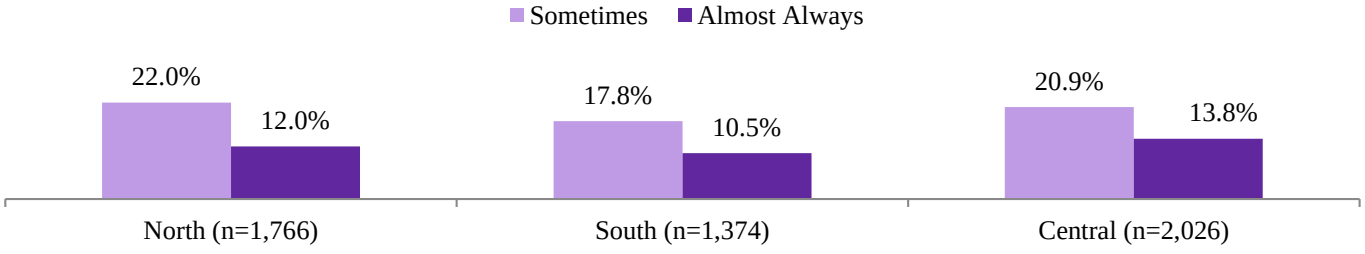
CalOptima language:



Age Category:

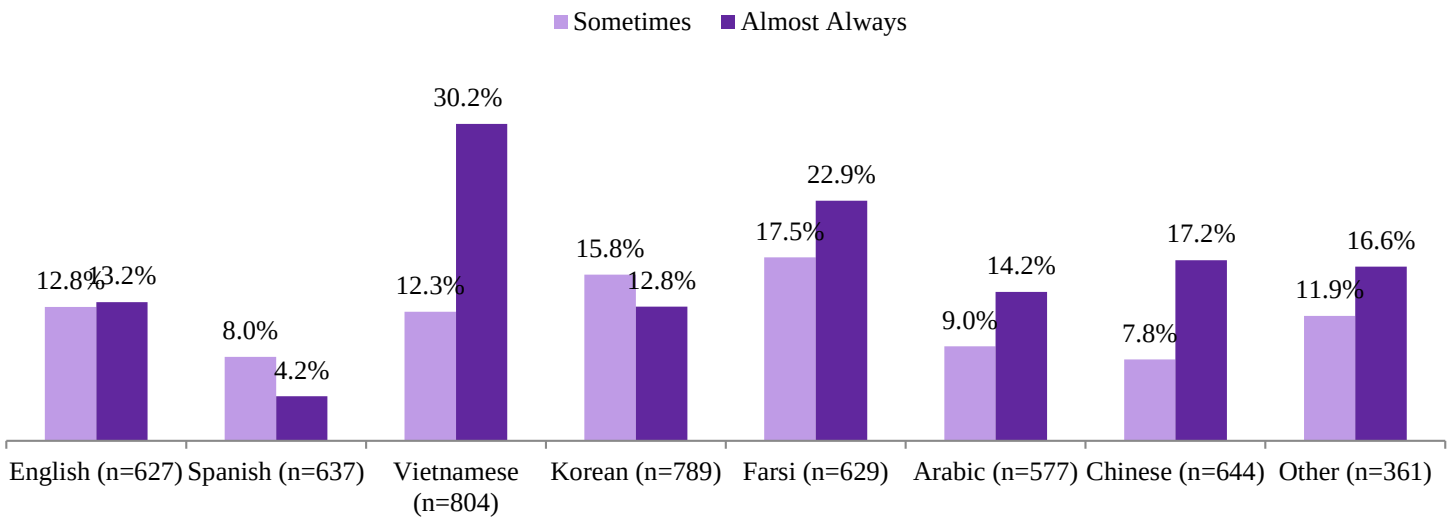


Region:

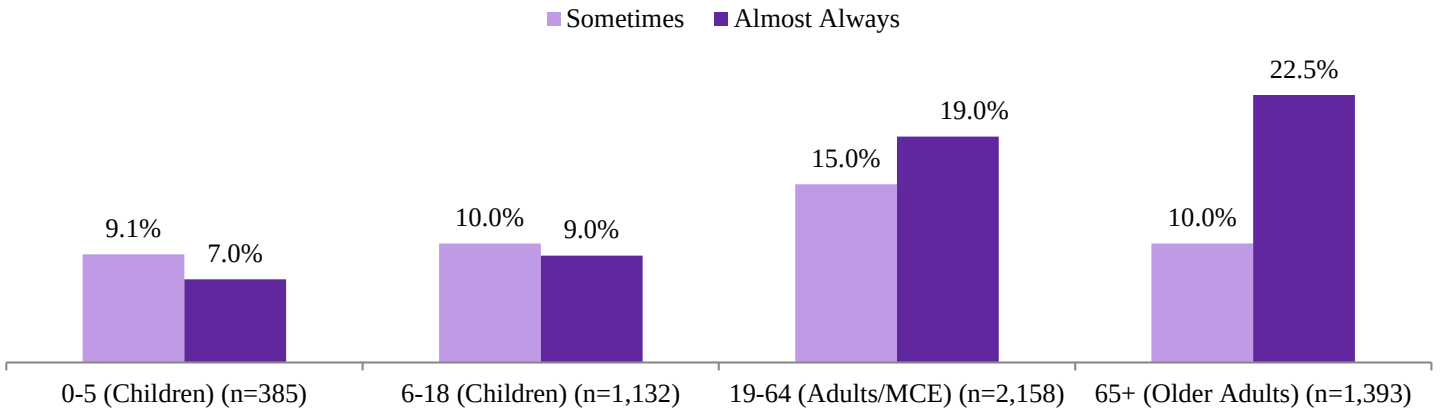


Housing:

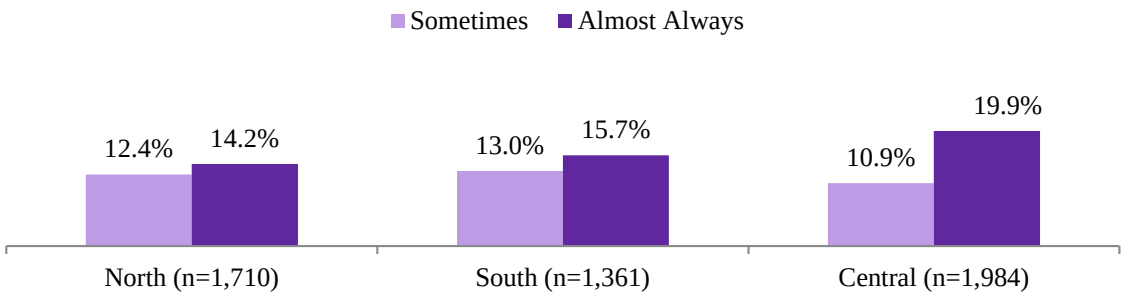
CalOptima language:



Age Category:

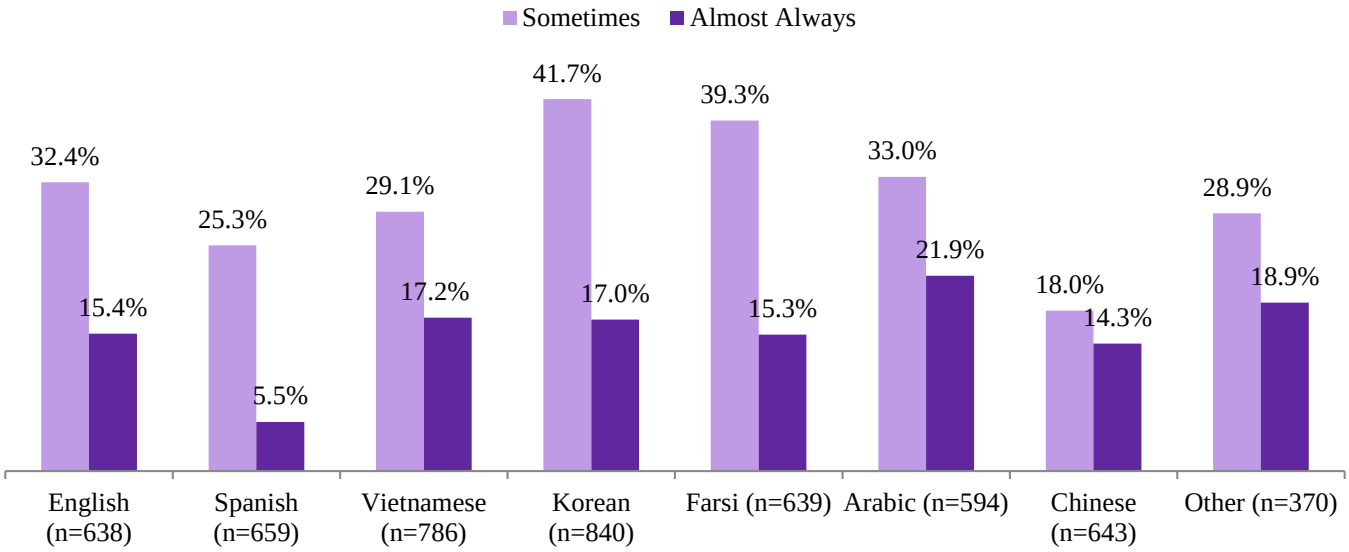


Region:

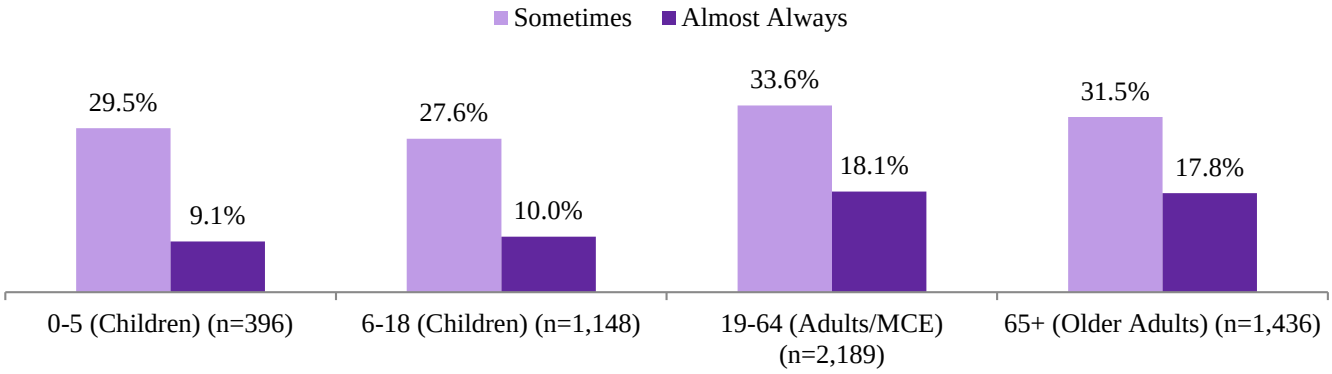


Money to buy things need:

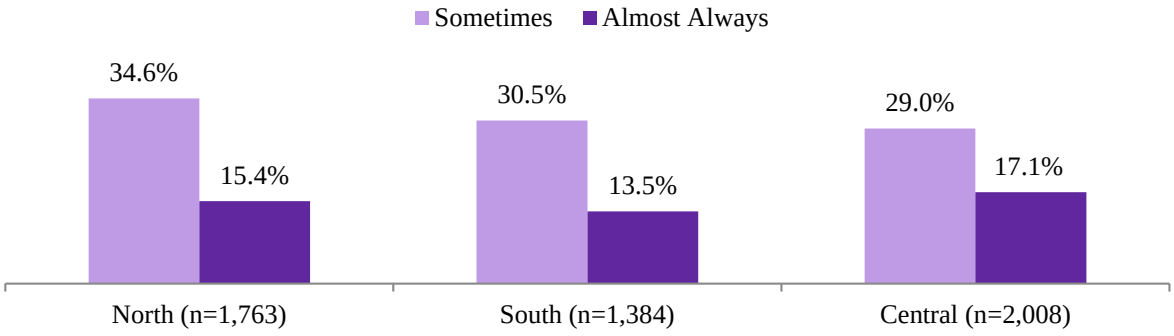
CalOptima language:



Age Category:

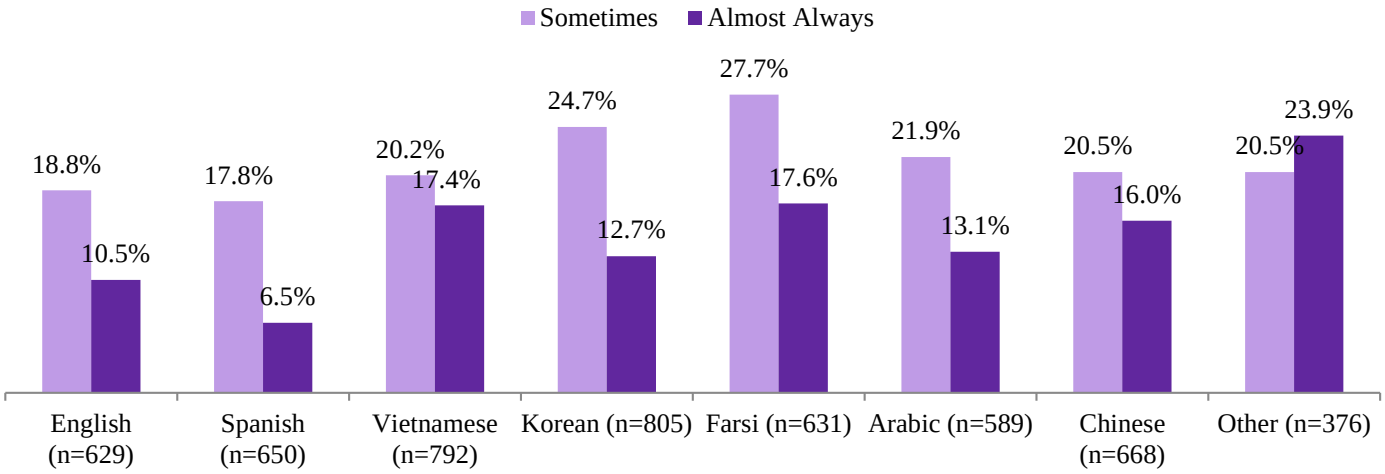


Region:

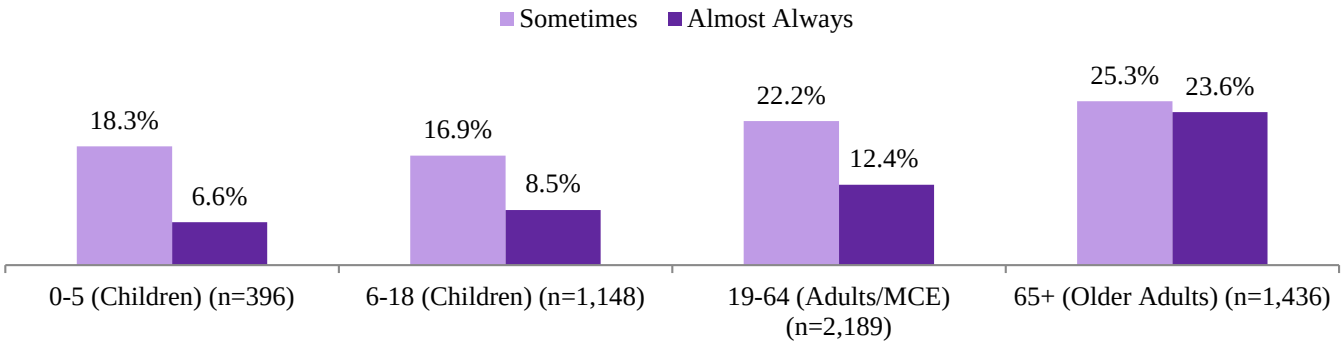


Transportation:

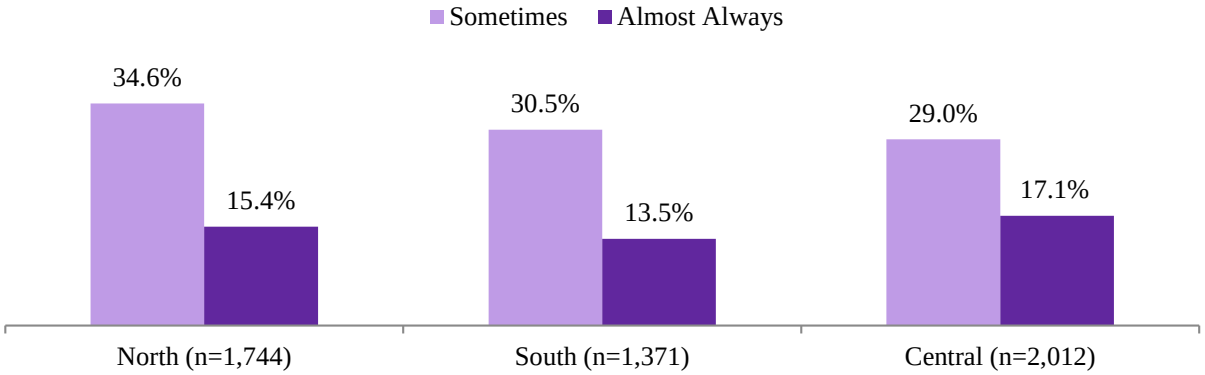
CalOptima language:



Age Category:

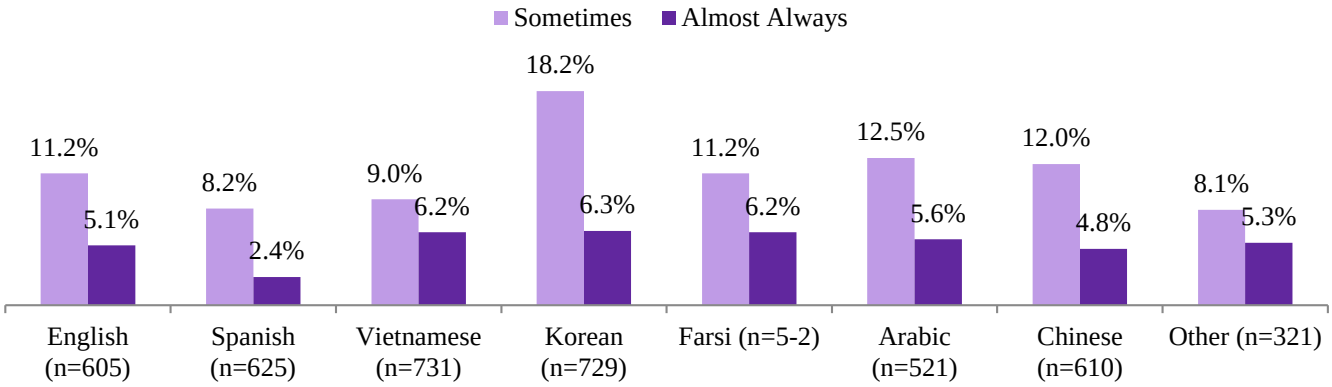


Region:

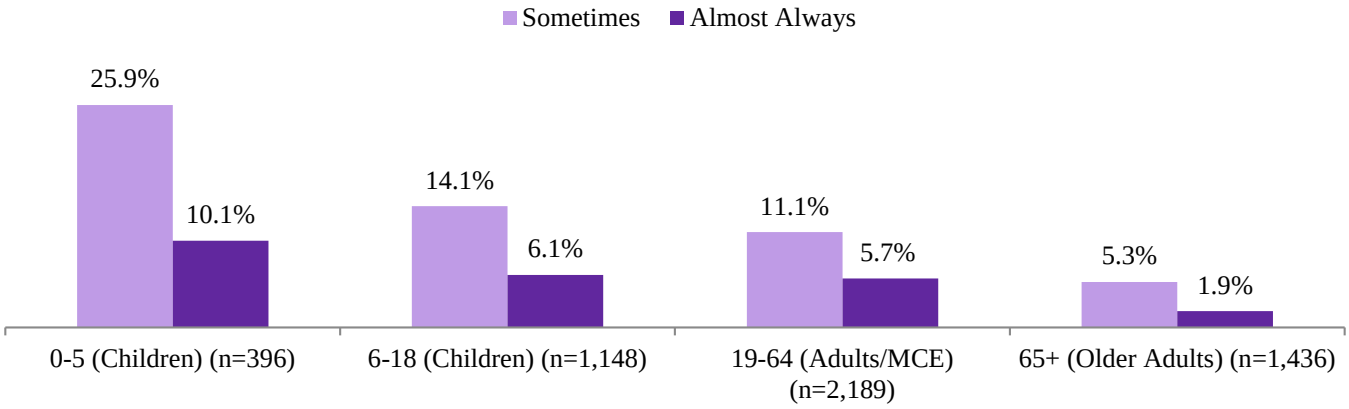


Child care:

CalOptima language:



Age Category:



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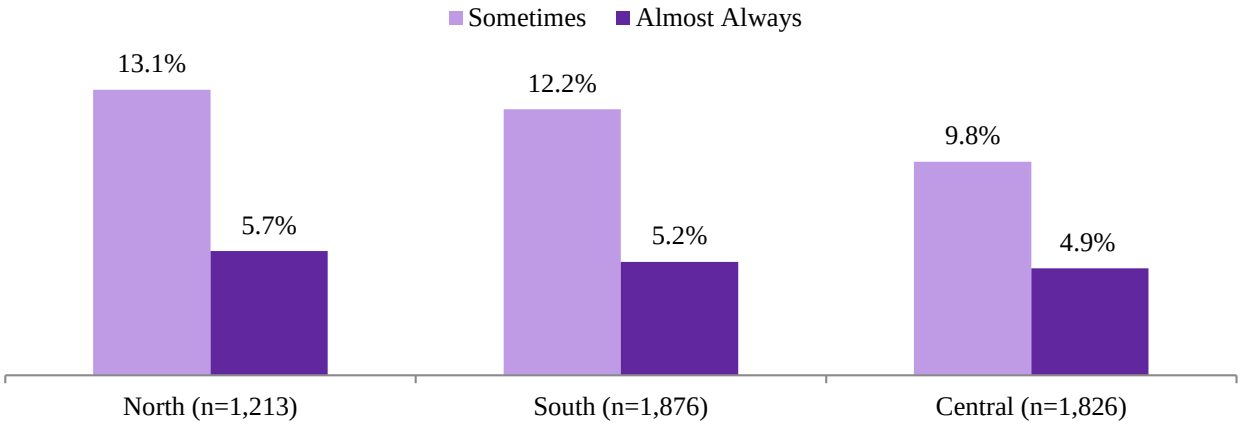
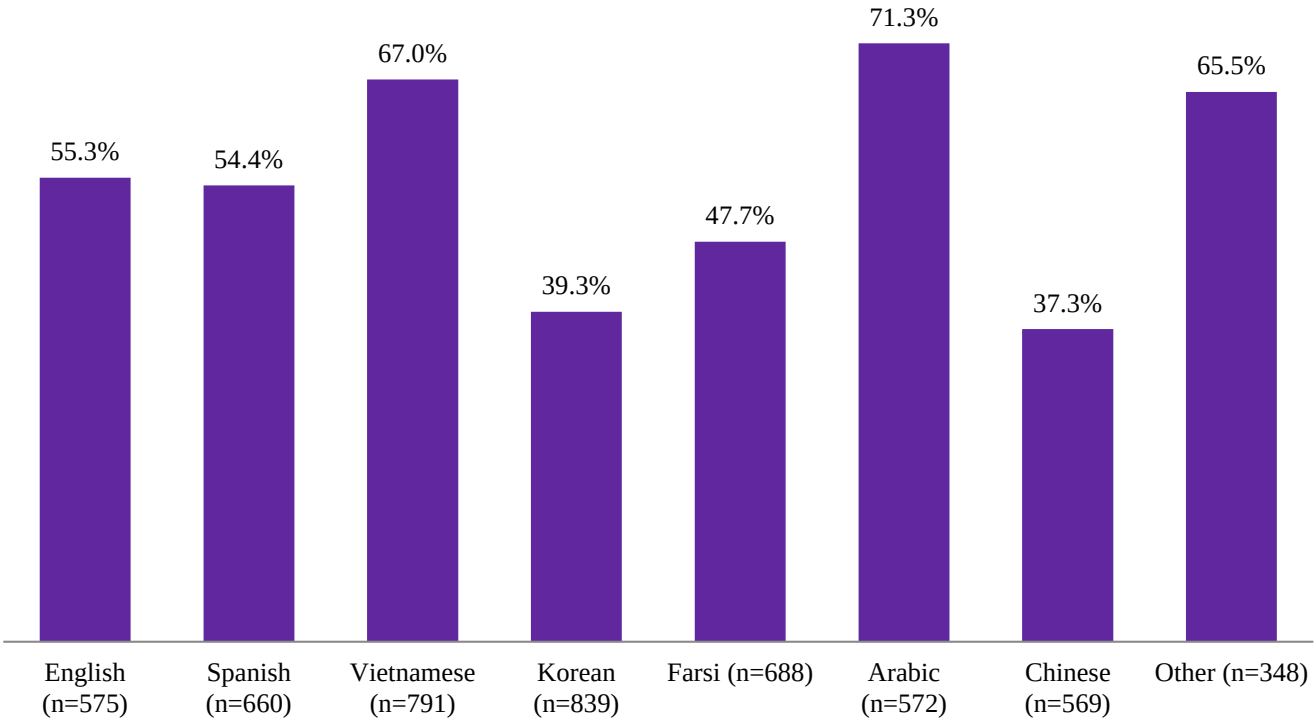


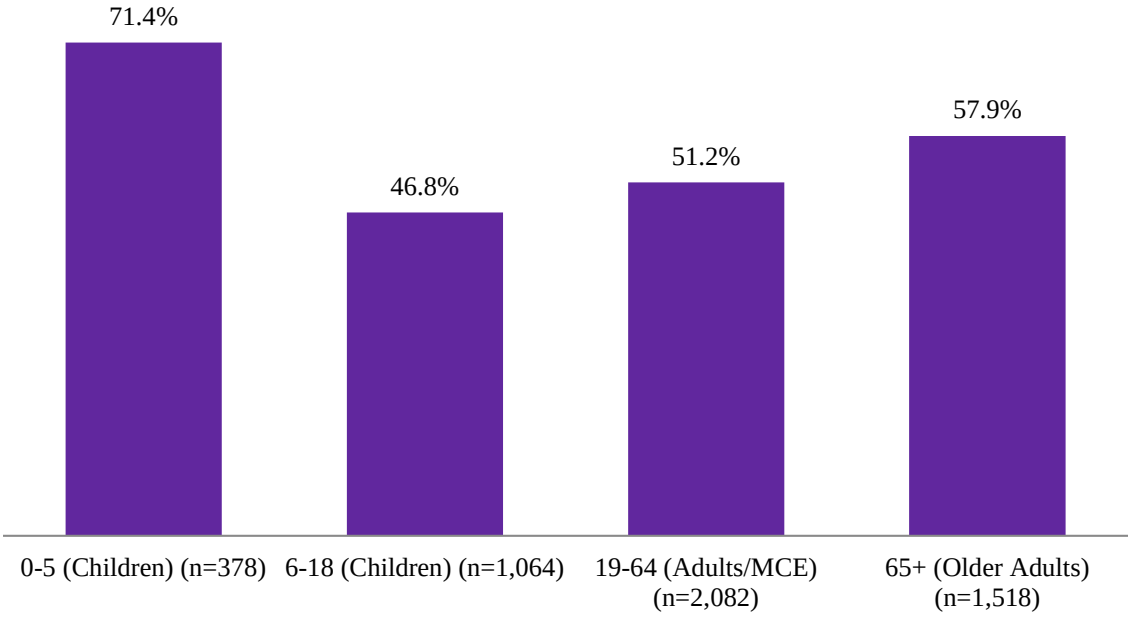
Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

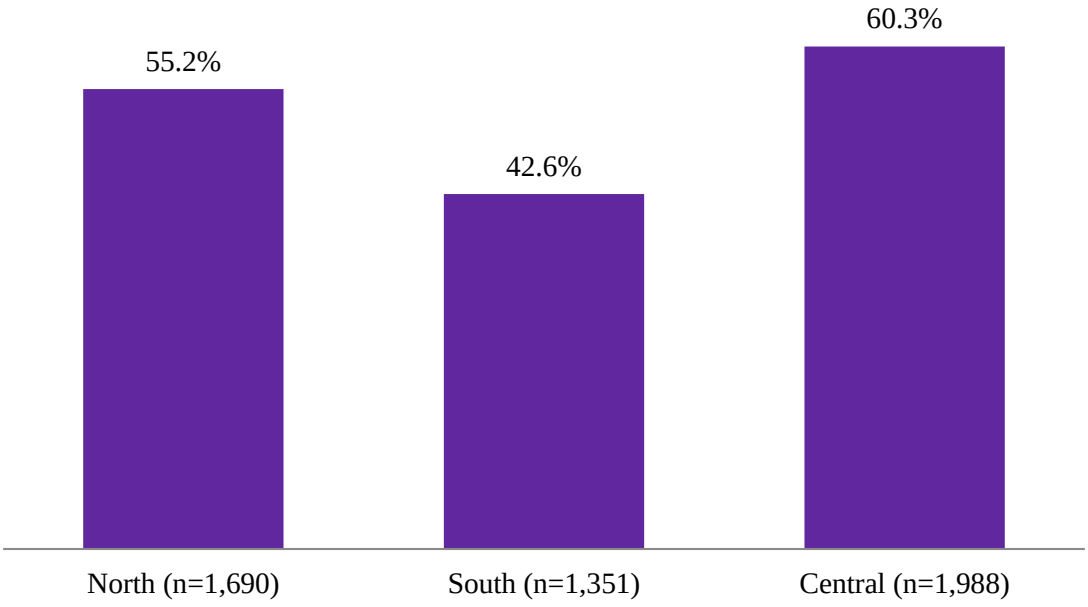
CalOptima language:



Age Category:



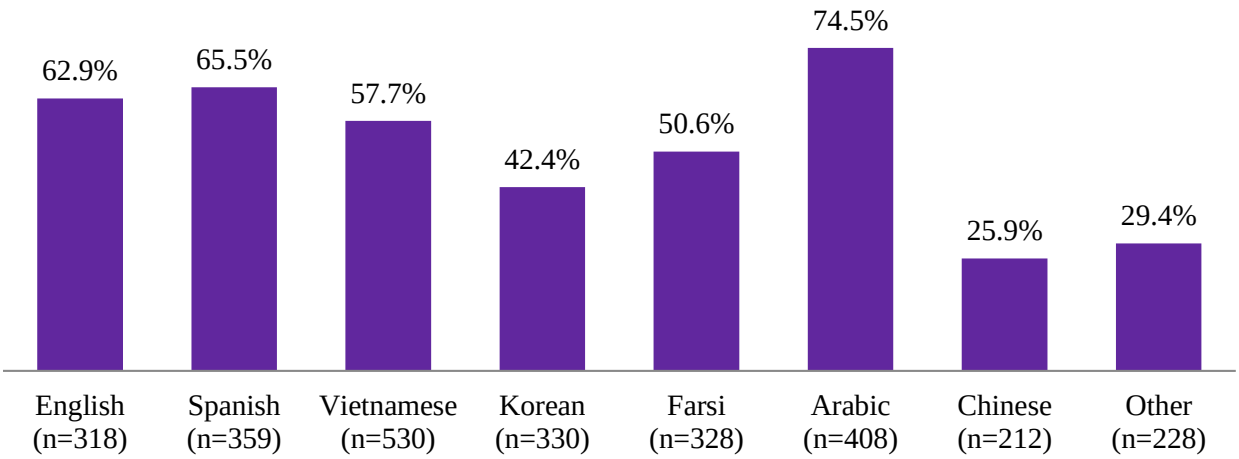
Region:



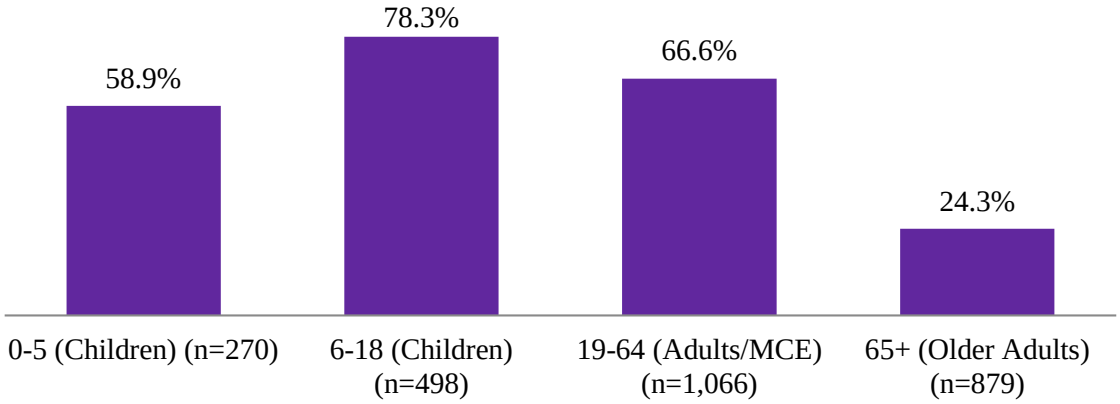
Type of public benefits that members receive[8]:

Receive CalFresh as a public benefit:

CalOptima language:



Age Category:



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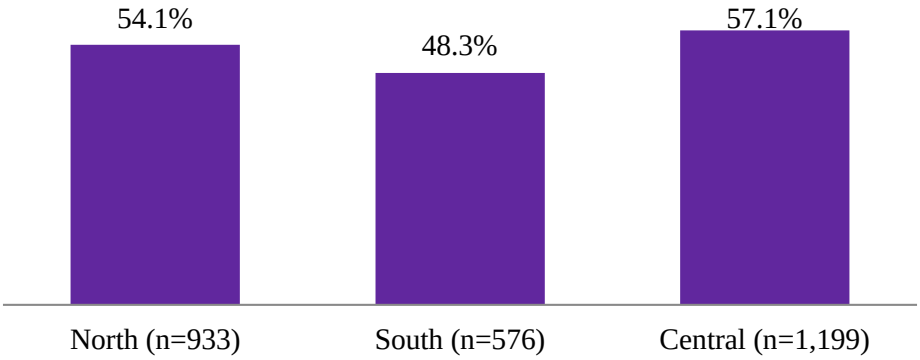
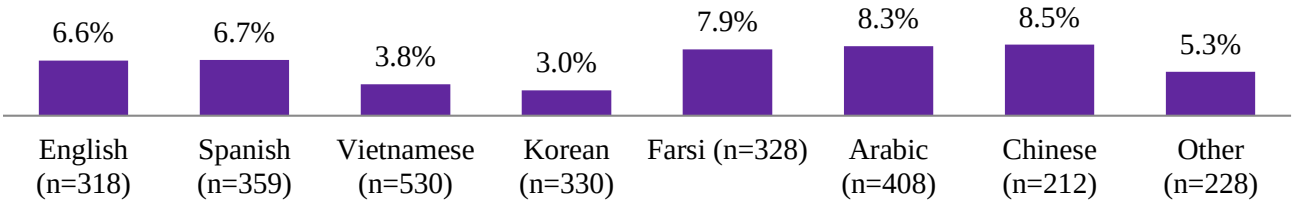


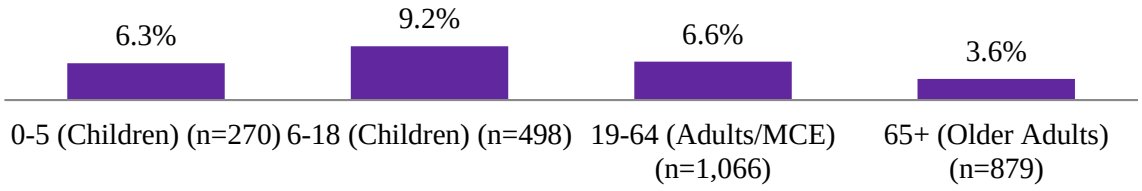
[8] Only reporting those who reported that they received at least one public benefit.

Receive TANF or CalWorks as a public benefit:

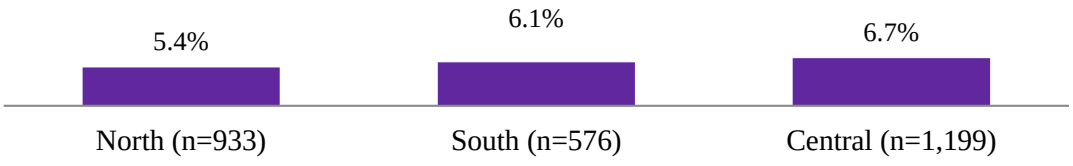
CalOptima language:



Age Category:

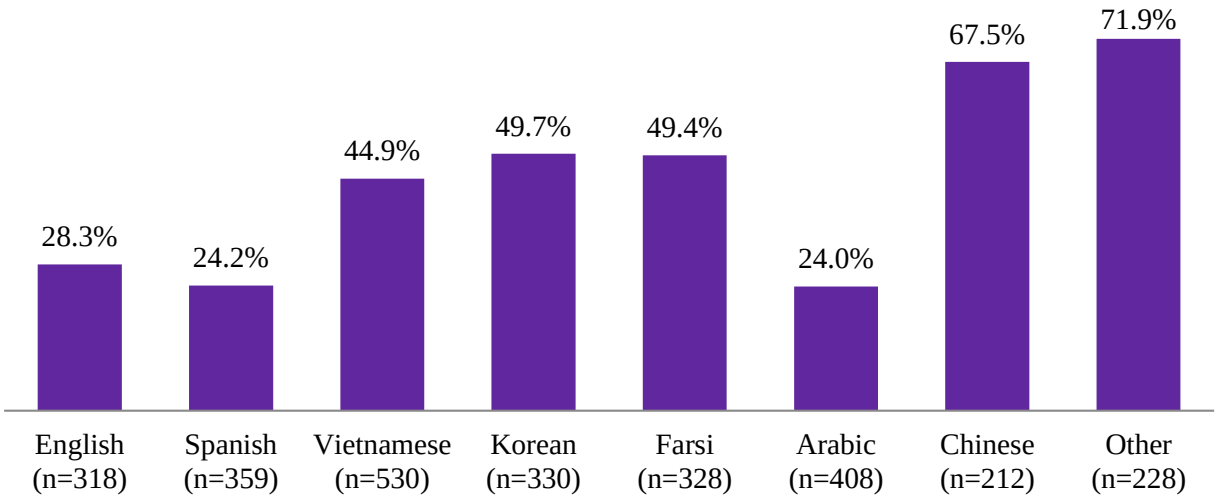


Region:

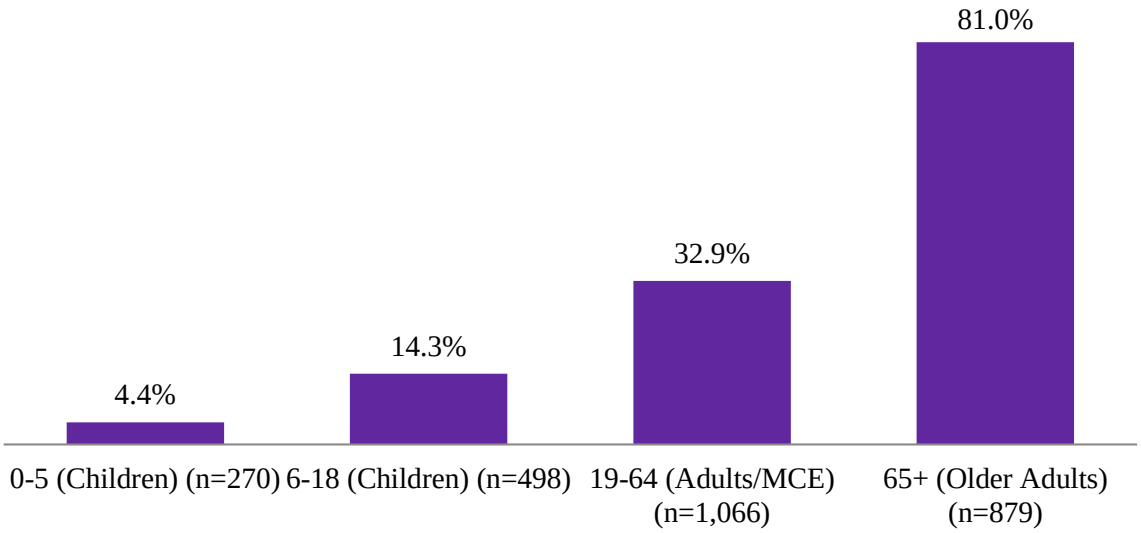


Receive SSI or SSDI as a public benefit:

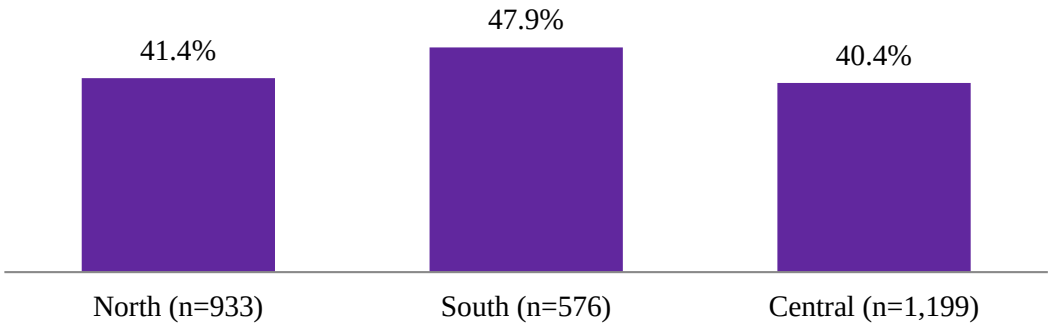
CalOptima language:



Age Category:

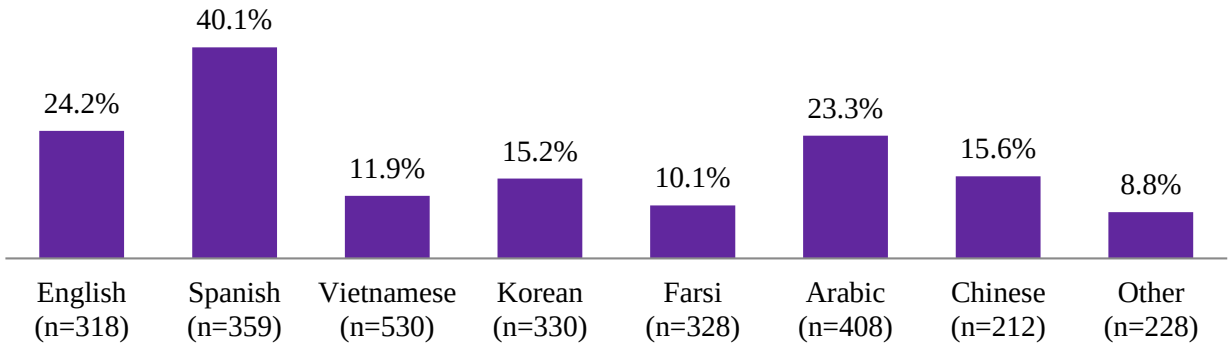


Region:

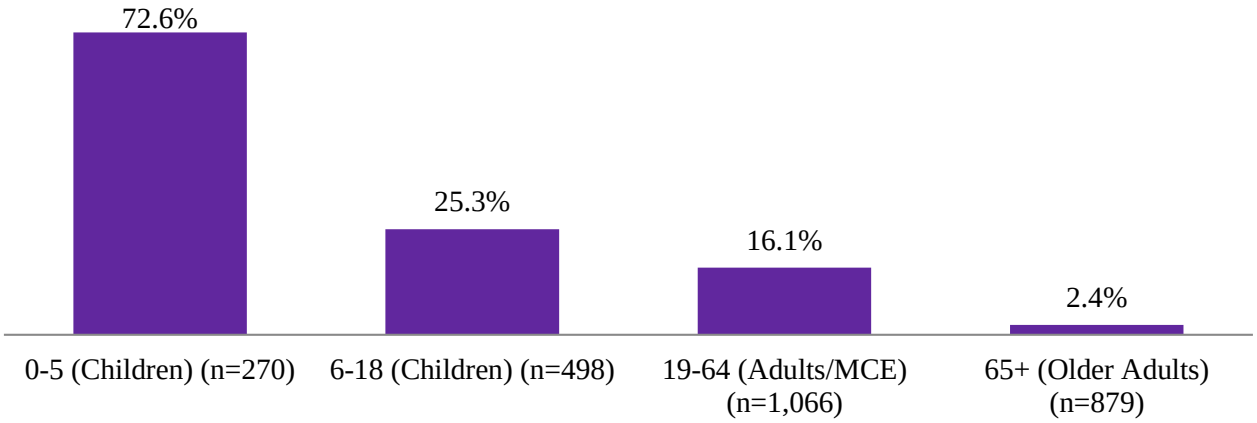


Receive WIC as a public benefit:

CalOptima language:



Age Category:



Region:

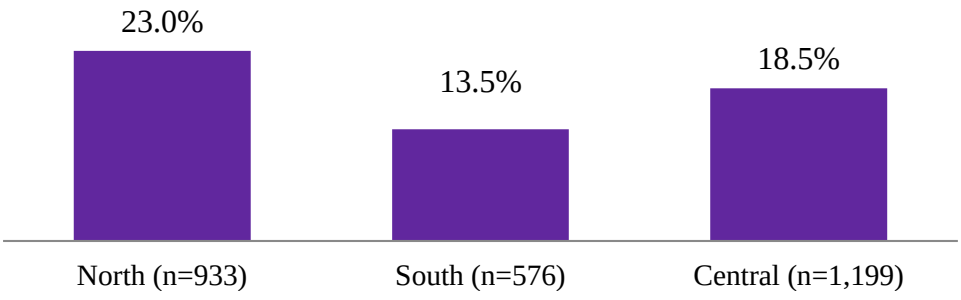


Exhibit 15. Personal activities participation:

CalOptima language:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	41.2%	6.4%	6.4%	45.9%	621
Spanish	19.1%	4.3%	3.1%	73.5%	607
Vietnamese	53.5%	3.3%	4.3%	38.9%	766
Korean	35.4%	6.3%	2.3%	56.0%	809
Farsi	28.5%	3.2%	3.4%	65.0%	537
Arabic	47.2%	5.9%	1.9%	45.0%	540
Chinese	16.8%	3.8%	3.1%	76.3%	583
Other	32.3%	4.0%	5.1%	58.6%	350
Do fun activities with others	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
English	63.3%	18.3%	7.4%	11.0%	635
Spanish	61.8%	13.0%	4.0%	21.2%	647
Vietnamese	49.6%	19.5%	9.3%	21.7%	789
Korean	51.9%	22.7%	7.3%	18.0%	859
Farsi	39.5%	25.0%	10.2%	**25.3%**	608
Arabic	54.8%	20.6%	6.7%	17.9%	586
Chinese	45.4%	12.1%	5.8%	**36.7%**	619
Other	46.3%	21.6%	11.6%	20.5%	361

Volunteer or charity	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	16.2%	15.8%	19.4%	48.6%	628
Spanish	15.9%	10.0%	9.9%	64.2%	628
Vietnamese	15.8%	19.1%	26.7%	38.3%	752
Korean	21.0%	13.2%	15.6%	50.2%	825
Farsi	15.4%	13.8%	19.9%	50.9%	578
Arabic	23.5%	18.1%	14.3%	44.2%	575
Chinese	16.5%	11.9%	14.0%	57.7%	607
Other	9.9%	7.0%	12.1%	71.0%	355

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	68.7%	11.5%	6.0%	13.7%	633
Spanish	66.0%	8.7%	2.8%	22.5%	644
Vietnamese	69.6%	6.6%	4.0%	19.8%	807
Korean	75.1%	10.1%	3.7%	11.2%	874
Farsi	68.9%	7.7%	5.6%	17.9%	627
Arabic	59.1%	11.8%	4.4%	24.7%	587
Chinese	71.9%	7.3%	3.8%	17.1%	661
Other	57.6%	10.2%	4.7%	27.5%	363

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	83.3%	6.0%	1.0%	9.6%	612
Spanish	85.1%	5.3%	1.0%	8.6%	590
Vietnamese	78.0%	5.1%	1.5%	15.4%	740
Korean	88.2%	6.3%	1.0%	4.5%	842
Farsi	84.3%	4.8%	1.9%	8.9%	516
Arabic	83.2%	5.5%	1.5%	9.8%	531
Chinese	86.9%	5.2%	1.1%	6.7%	610
Other	80.3%	6.7%	3.5%	9.5%	315

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	76.7%	12.2%	2.9%	8.2%	621
Spanish	80.1%	7.7%	2.9%	9.3%	613
Vietnamese	78.2%	7.7%	1.9%	12.1%	725
Korean	73.6%	13.8%	4.6%	8.0%	864
Farsi	78.4%	9.9%	3.7%	8.0%	538
Arabic	74.5%	11.4%	2.7%	11.4%	553
Chinese	85.9%	5.3%	2.4%	6.3%	618
Other	82.9%	9.2%	3.5%	4.4%	315

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	0.8%	1.1%	6.2%	91.9%	632
Spanish	0.2%	0.3%	2.5%	97.1%	651
Vietnamese	2.6%	0.6%	3.1%	93.7%	772
Korean	0.8%	0.8%	6.5%	91.8%	846
Farsi	1.3%	1.0%	2.9%	94.8%	594
Arabic	5.0%	2.4%	1.0%	91.6%	582
Chinese	7.5%	2.3%	3.3%	86.8%	598
Other	2.2%	2.0%	8.1%	87.7%	358

Age Category:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	32.2%	3.4%	2.0%	62.4%	348
6-18 (Children)	33.0%	3.9%	2.5%	60.6%	1,077
19-64 (Adults/MCE)	43.2%	5.6%	4.2%	47.0%	2,093
65+ (Older Adults)	24.3%	4.3%	4.2%	67.2%	1,295

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	75.0%	9.8%	2.9%	12.2%	376
6-18 (Children)	72.5%	12.3%	4.7%	10.6%	1,137
19-64 (Adults/MCE)	43.6%	24.2%	9.3%	23.0%	2,190
65+ (Older Adults)	41.9%	19.2%	8.6%	30.3%	1,401

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	14.5%	10.4%	11.0%	64.1%	365
6-18 (Children)	22.7%	18.3%	17.2%	41.8%	1,117
19-64 (Adults/MCE)	18.0%	14.9%	20.8%	46.3%	2,142
65+ (Older Adults)	12.1%	10.1%	12.2%	65.6%	1,324

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	69.2%	7.0%	1.9%	21.9%	370
6-18 (Children)	77.9%	8.4%	3.2%	10.5%	1,148
19-64 (Adults/MCE)	62.2%	12.6%	5.7%	19.5%	2,211
65+ (Older Adults)	69.3%	4.9%	3.6%	22.2%	1,467

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	89.8%	3.6%	0.6%	6.1%	362
6-18 (Children)	90.2%	4.5%	0.9%	4.3%	1,084
19-64 (Adults/MCE)	80.5%	6.7%	1.7%	11.0%	2,061
65+ (Older Adults)	82.4%	5.2%	1.6%	10.8%	1,249

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	79.0%	6.4%	3.6%	11.0%	362
6-18 (Children)	83.2%	7.7%	2.4%	6.7%	1,110
19-64 (Adults/MCE)	70.7%	14.3%	4.3%	10.8%	2,105
65+ (Older Adults)	86.5%	5.3%	1.7%	6.5%	1,270

Visit a casino or gamble on the internet	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	3.0%	0.5%	1.6%	94.8%	368
6-18 (Children)	2.3%	0.6%	1.8%	95.3%	1,134
19-64 (Adults/MCE)	1.9%	1.0%	5.4%	91.7%	2,171
65+ (Older Adults)	3.2%	2.3%	4.6%	89.9%	1,360

Region:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	35.3%	5.4%	3.7%	55.6%	1,639
South	28.8%	4.2%	4.0%	62.9%	1,252
Central	38.8%	4.4%	3.4%	53.4%	1,910

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	51.8%	20.1%	8.0%	20.0%	1,757
South	47.7%	21.1%	8.0%	23.2%	1,345
Central	55.0%	16.6%	6.9%	21.5%	1,989

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	17.7%	13.8%	16.0%	52.5%	1,702
South	16.8%	13.2%	16.8%	53.3%	1,307
Central	17.1%	14.9%	17.9%	50.1%	1,927

Physical fitness	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	67.4%	10.2%	4.9%	17.5%	1,780
South	69.4%	8.8%	4.4%	17.4%	1,387
Central	67.9%	8.3%	3.7%	20.1%	2,017

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	86.8%	4.7%	0.8%	7.7%	1,668
South	86.0%	5.3%	1.8%	6.9%	1,230
Central	79.9%	6.6%	1.7%	11.8%	1,848

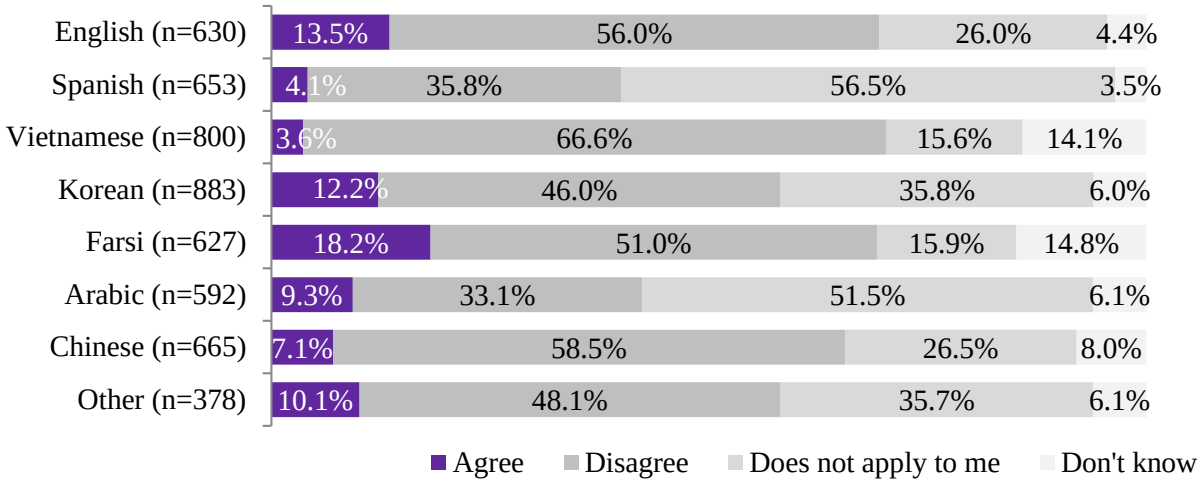
Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	76.2%	10.9%	3.8%	9.1%	1,694
South	81.0%	9.2%	3.3%	6.5%	1,263
Central	78.5%	9.2%	2.3%	9.9%	1,880

Visit a casino or gamble on the internet	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	1.5%	0.9%	4.5%	93.2%	1,726
South	4.0%	1.1%	3.7%	91.3%	1,327
Central	2.2%	1.7%	4.0%	92.1%	1,969

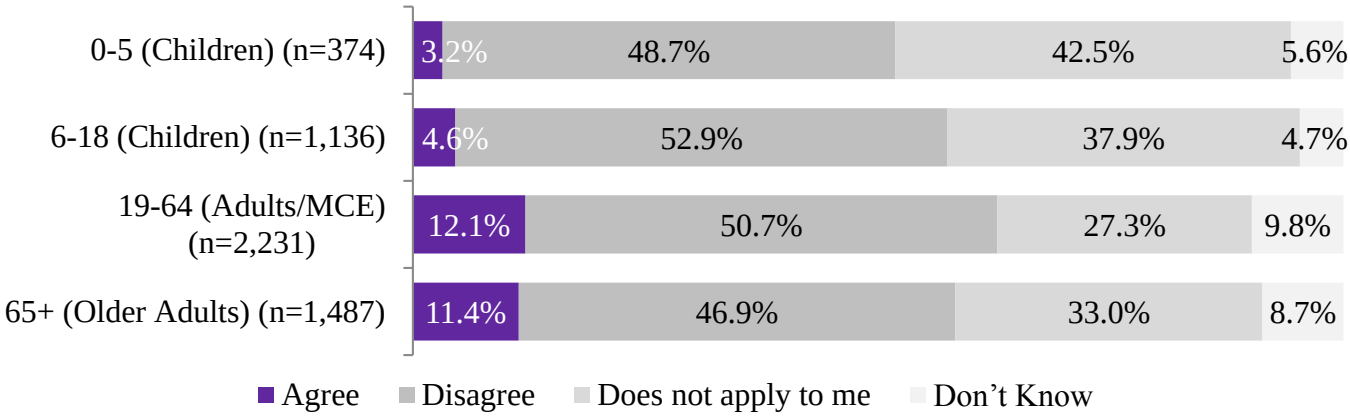
Exhibit 16. Feelings towards community and home enviroment:

Feeling lonely and isolated:

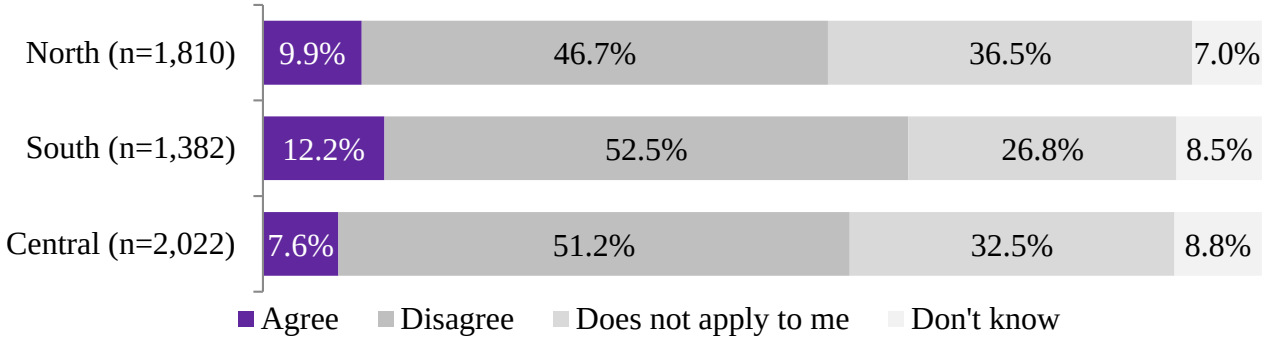
CalOptima language:



Age Category:

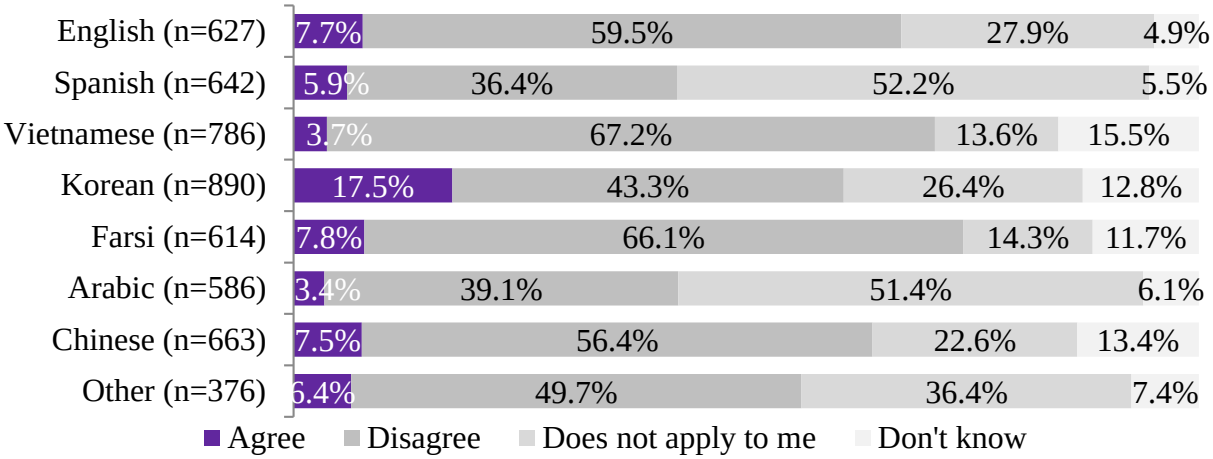


Region:

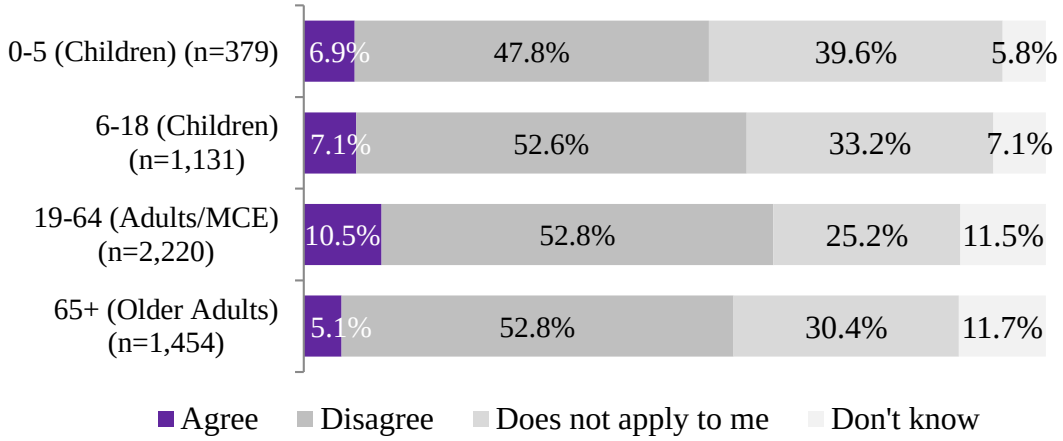


Feel not treated equally because of ethnic and culutral backgrounds:

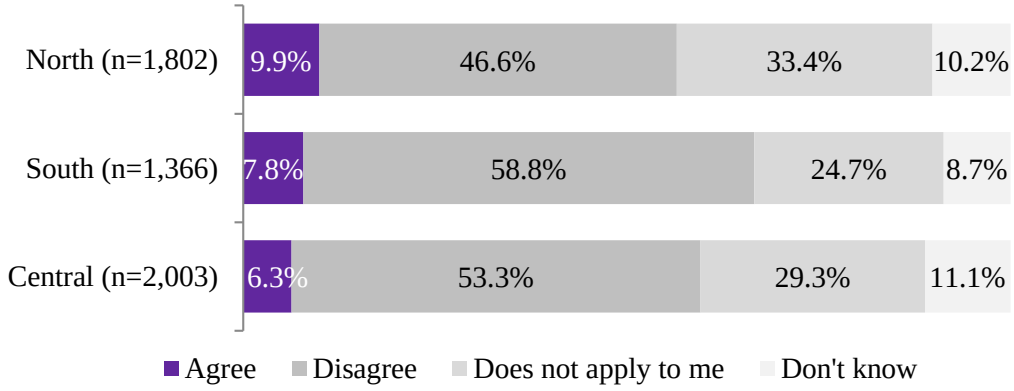
CalOptima language:



Age Category:

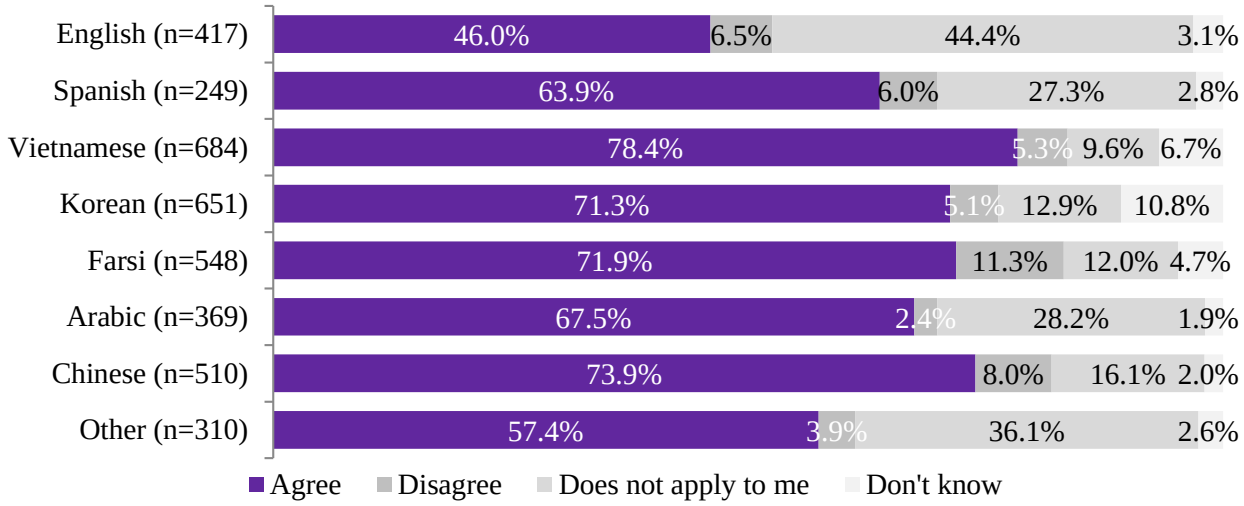


Region:



Feel child respects them as a parent[9]:

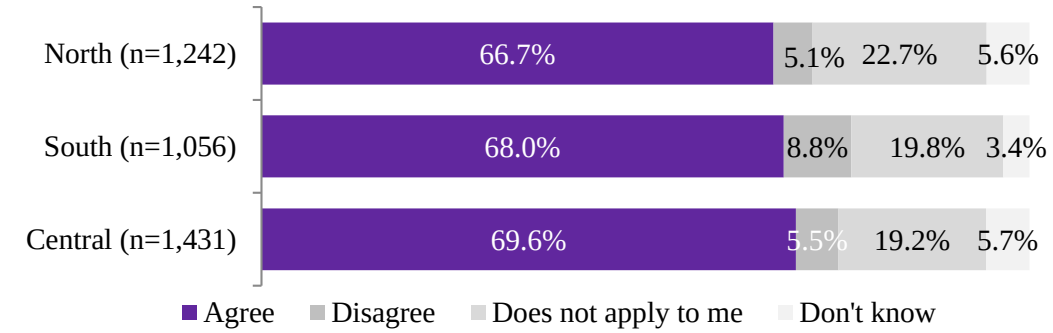
CalOptima language:



Age Category:



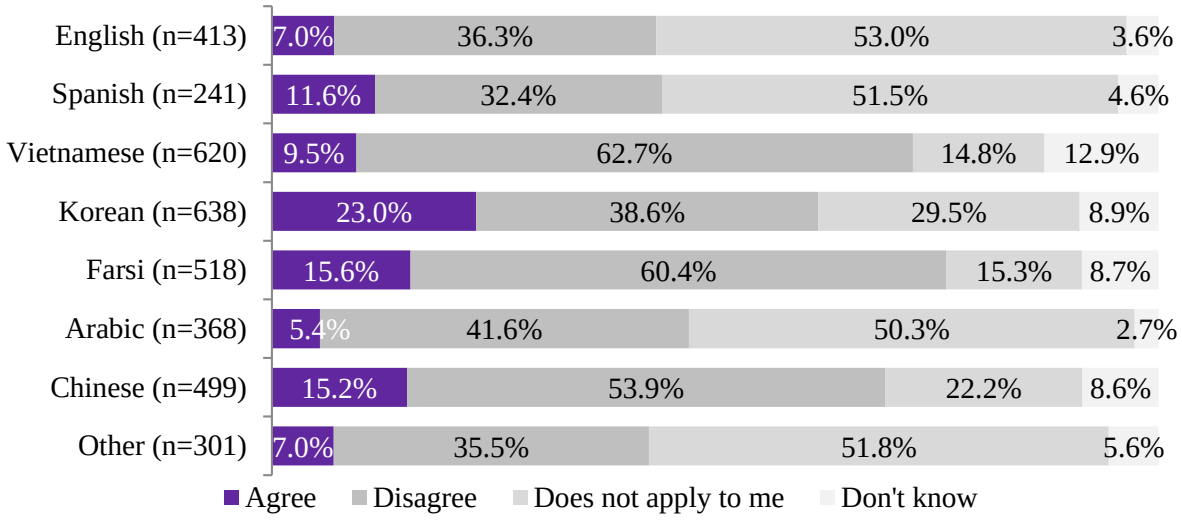
Region:



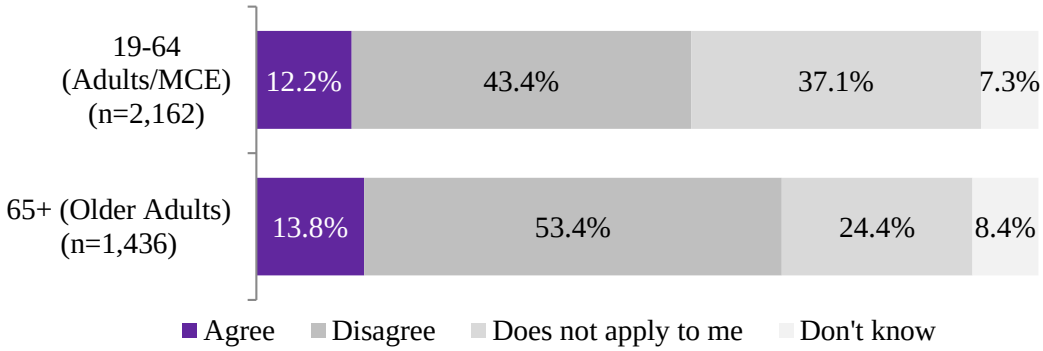
[9] Only reported those who are over 18 years old.

Feel child's attitudes and behavior conflict with cultural values[10]:

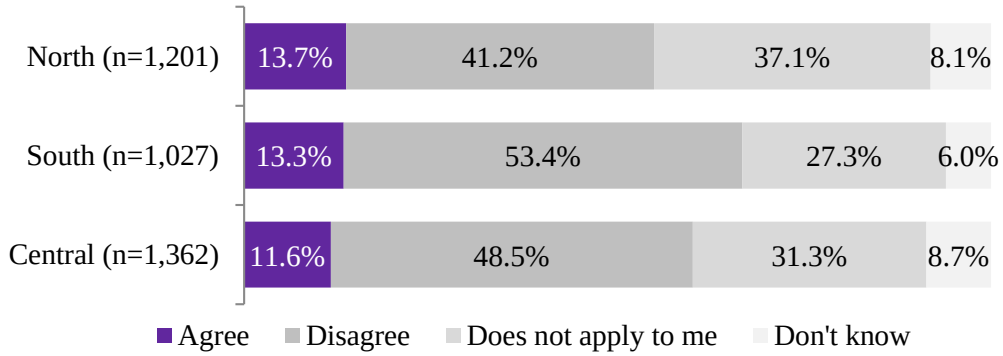
CalOptima language:



Age Category:



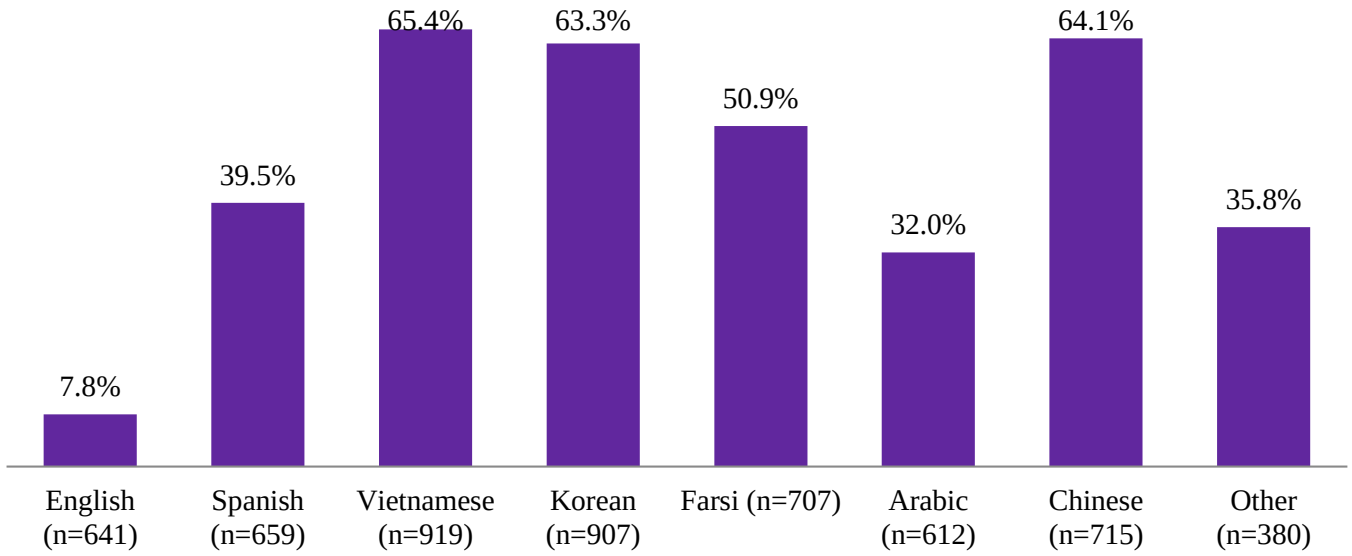
Region:



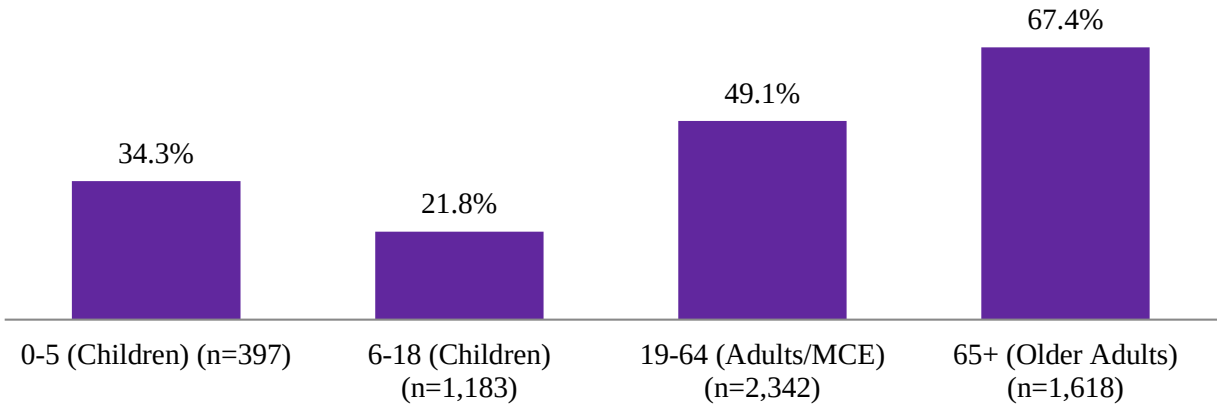
[10] Only reported those who are over 18 years old.

Exhibit 17. Members who reported that they speak English "not well":

CalOptima language:



Age Category:



Region:

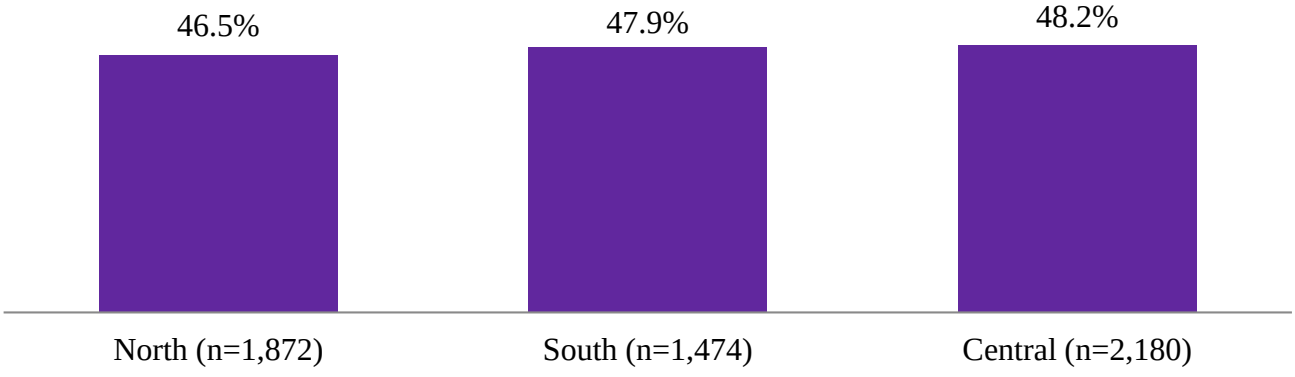


Exhibit 18. Employment status[11,12]

CalOptima language:

CalOptima language	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
English	36.7%	9.8%	7.2%	9.4%	13.4%	15.8%	20.4%	417
Spanish	21.7%	7.8%	11.6%	4.7%	21.3%	17.1%	28.3%	258
Vietnamese	32.1%	1.8%	12.1%	6.6%	24.4%	17.0%	20.0%	761
Korean	18.2%	11.6%	21.3%	6.9%	24.5%	10.0%	16.5%	638
Farsi	18.0%	4.4%	15.3%	7.6%	19.5%	26.5%	29.9%	616
Arabic	25.5%	4.2%	21.1%	9.4%	15.7%	11.9%	22.0%	427
Chinese	14.0%	3.8%	14.2%	4.9%	45.0%	6.8%	19.5%	529
Other	15.7%	3.4%	8.9%	3.7%	37.5%	10.2%	30.8%	325

Age Category:

Age Category	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
19-64 (Adults/MCE)	35.8%	8.3%	17.5%	10.9%	5.9%	17.6%	15.3%	2,370
65+ (Older Adults)	4.1%	1.7%	10.1%	0.7%	53.7%	10.5%	33.3%	1,601

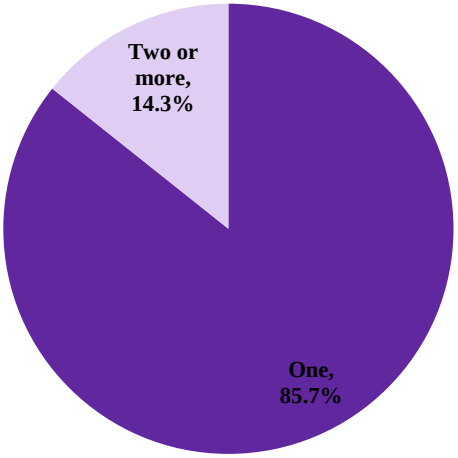
Region:

Region	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
North	24.0%	6.7%	15.9%	6.7%	23.6%	12.7%	22.5%	1,269
South	17.3%	6.6%	16.7%	7.3%	26.6%	17.3%	22.1%	1,129
Central	26.1%	4.0%	11.7%	6.5%	25.6%	14.7%	23.2%	1,561

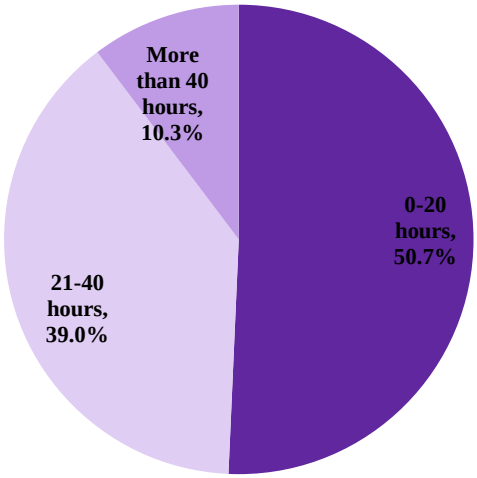
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]

Number of jobs members have

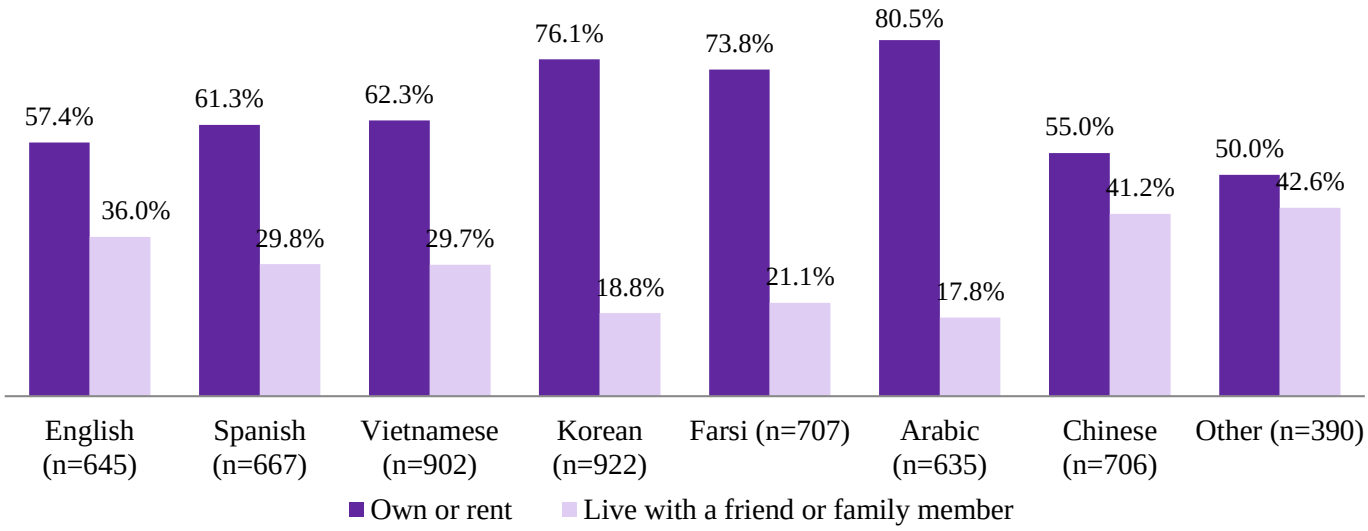


Number of hours that members work each week

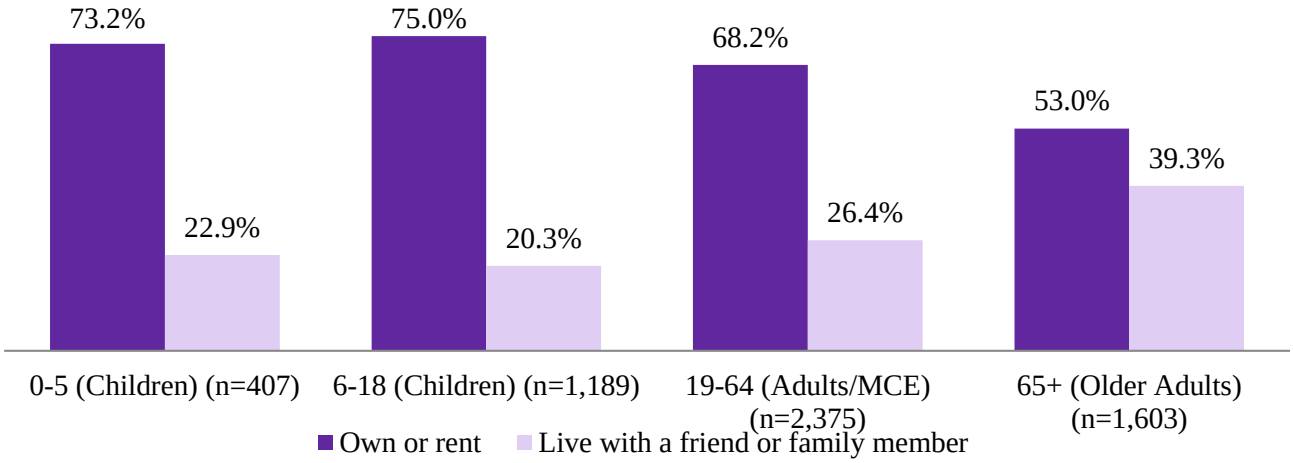


[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

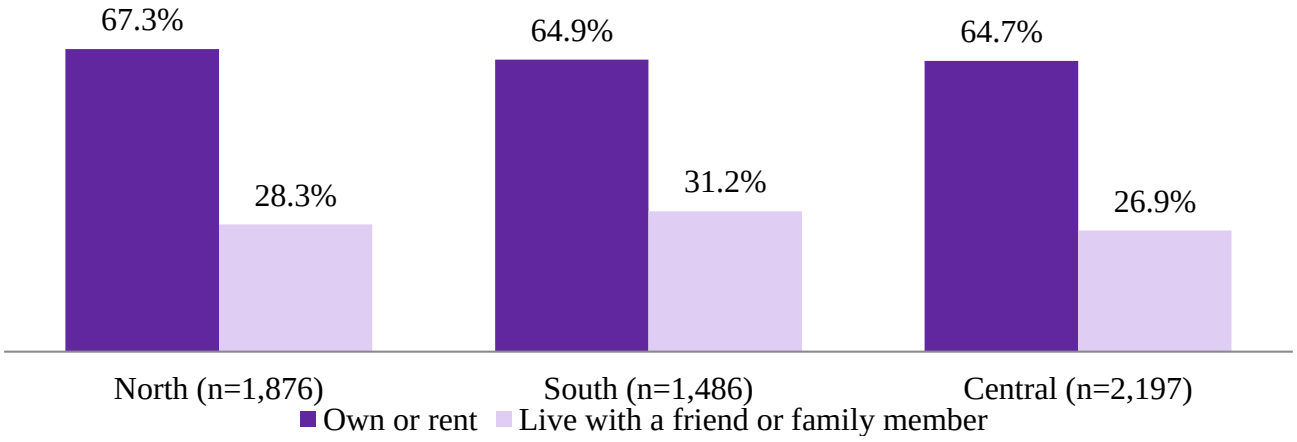
Exhibit 20. Members' living situation[14]



Age Category:



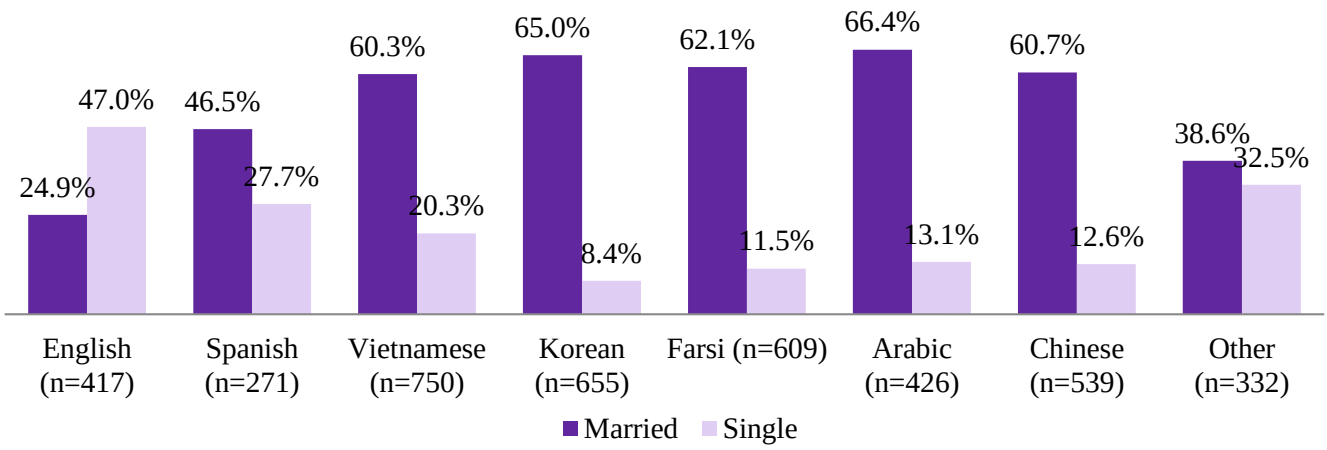
Region:



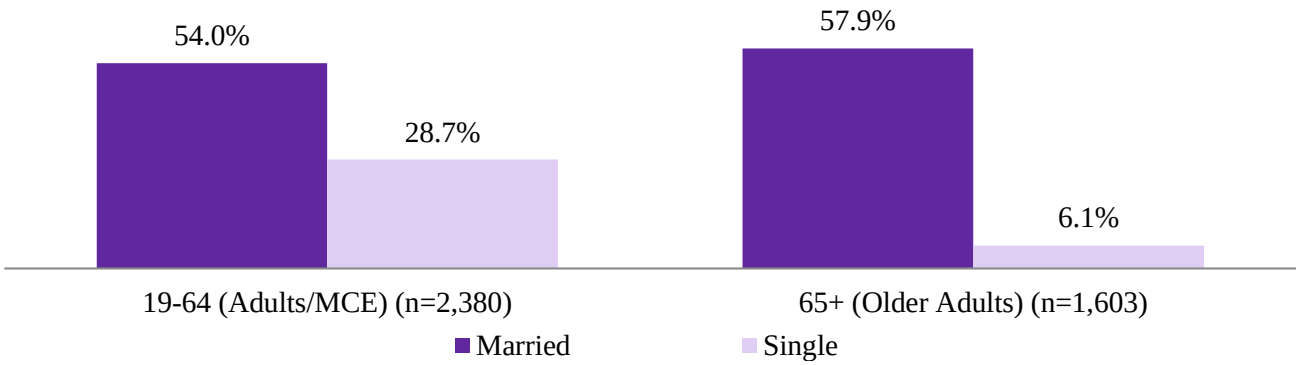
[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

Exhibit 21. Marital status of members[15],[16]

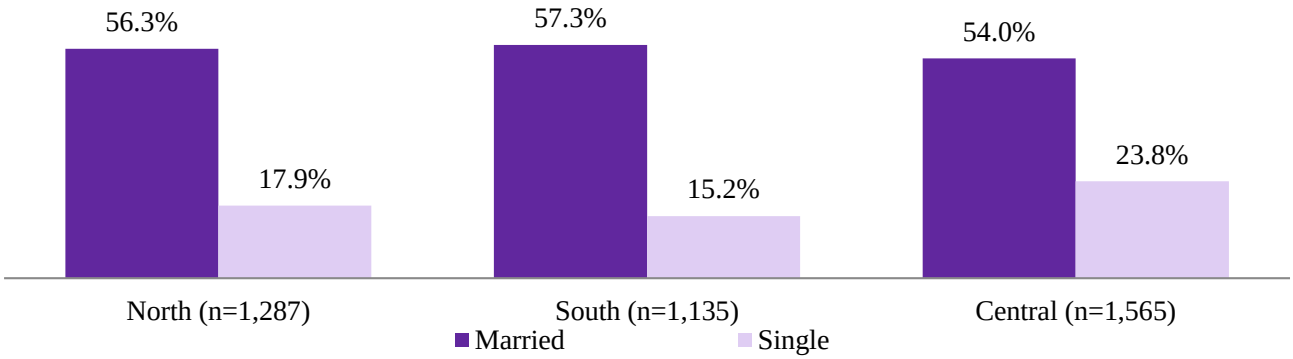
CalOptima language:



Age Category:



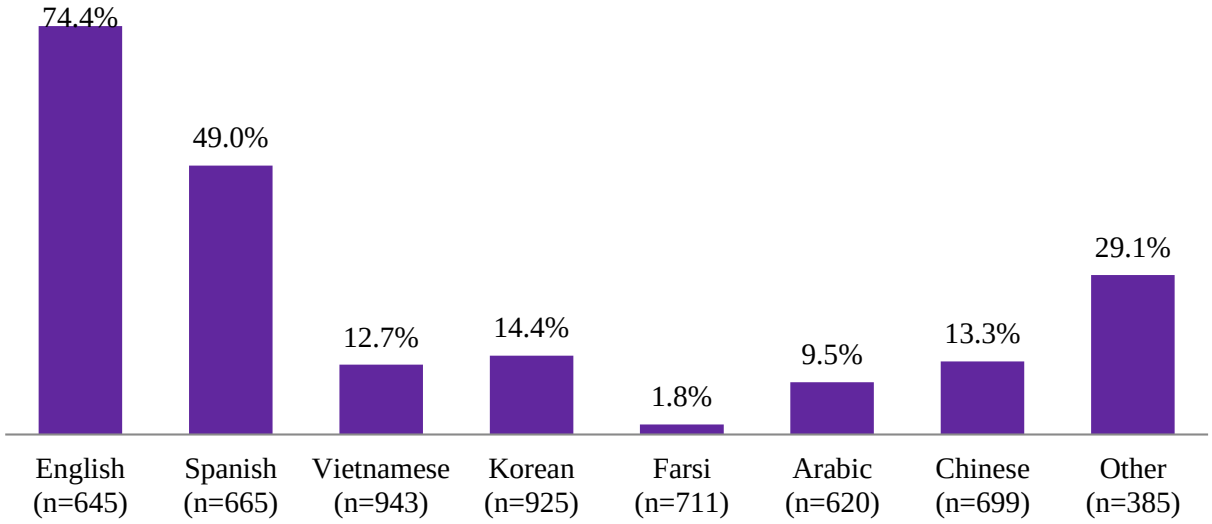
Region:



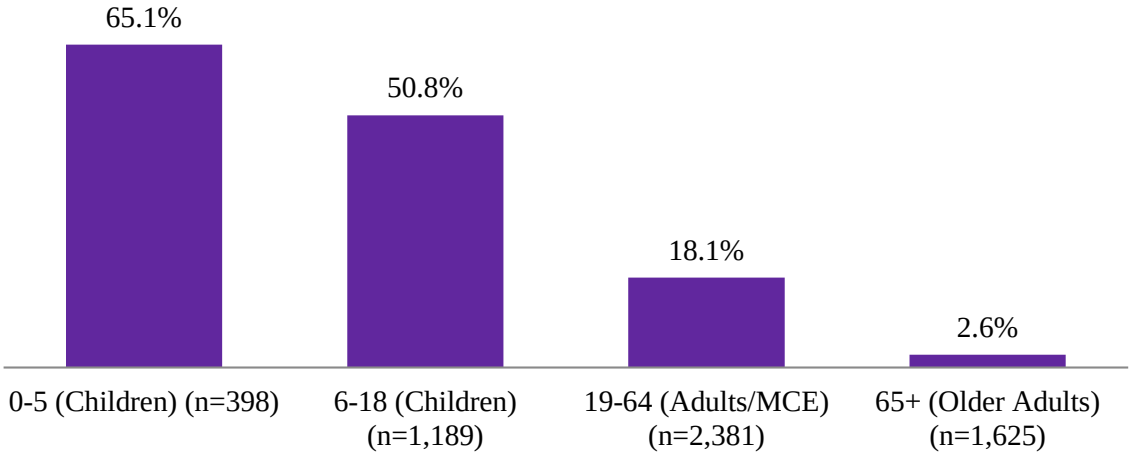
[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

Exhibit 22. Percent of members who were born in the United States:

CalOptima language:



Age Category:



Region:

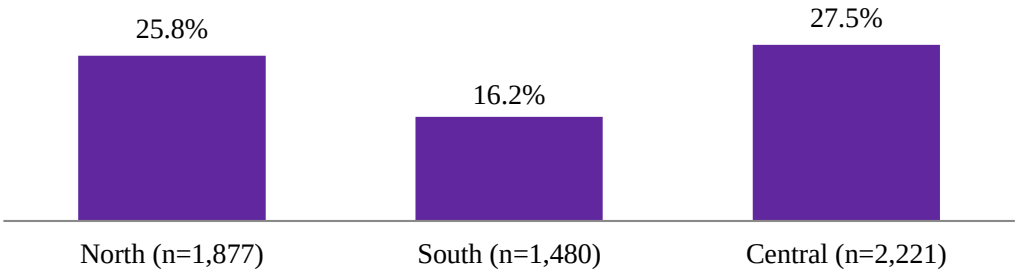
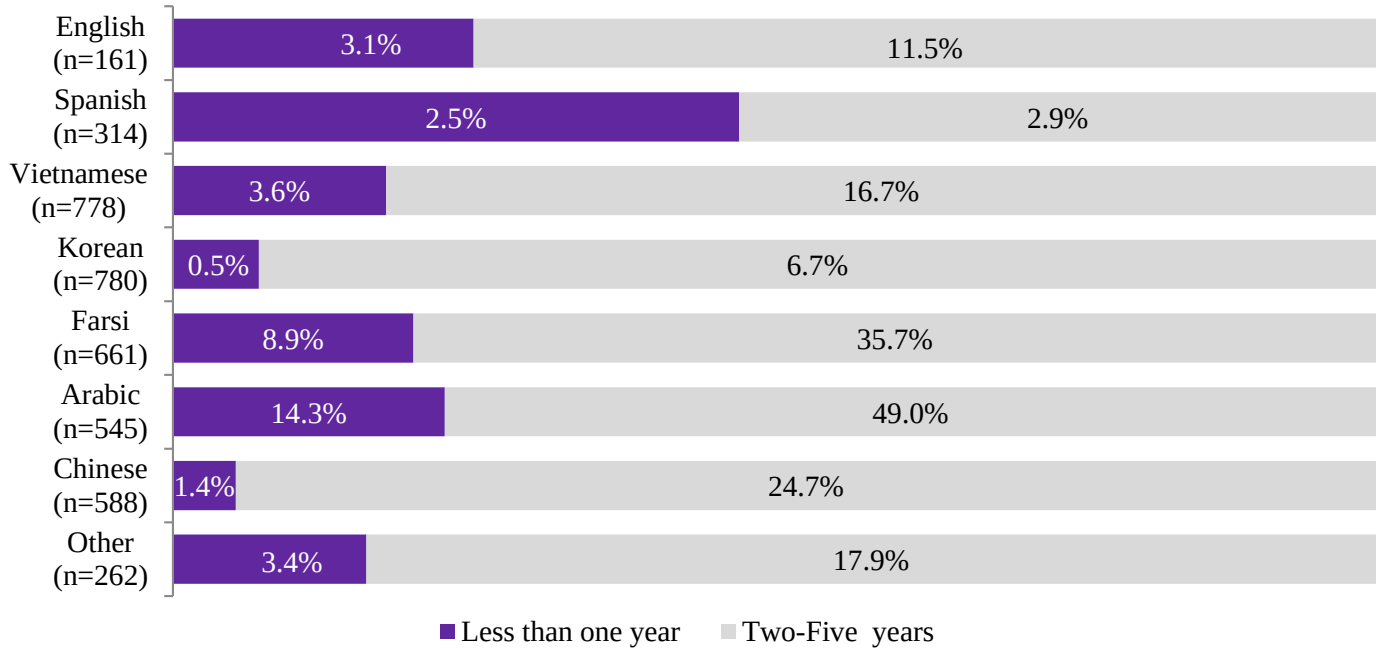
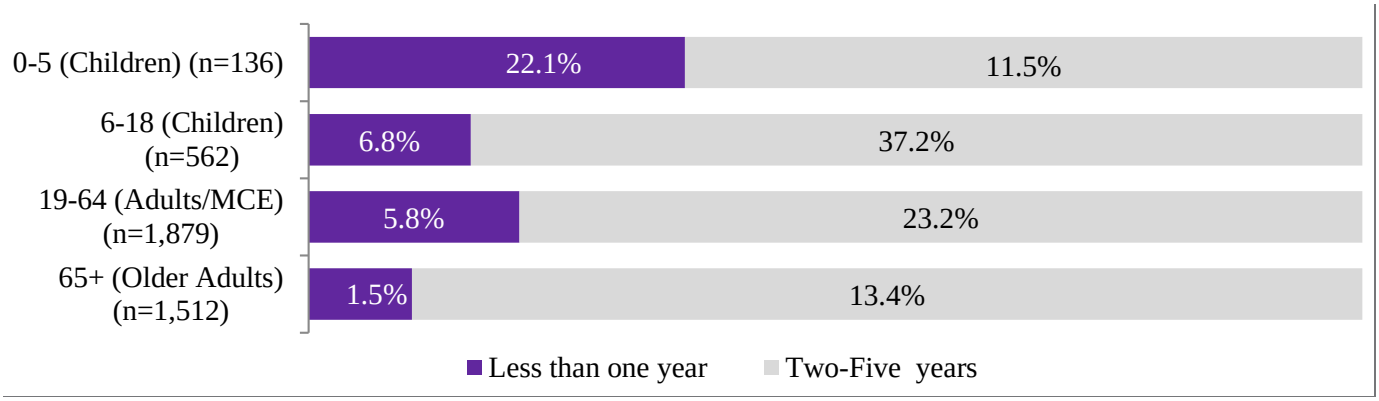


Exhibit 23. Length of time lived in the United States of those not born in the United States

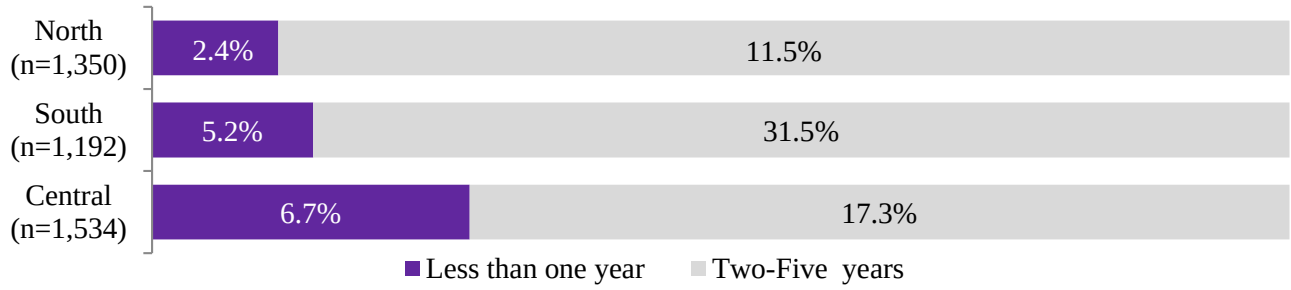
CalOptima language:



Age Category:



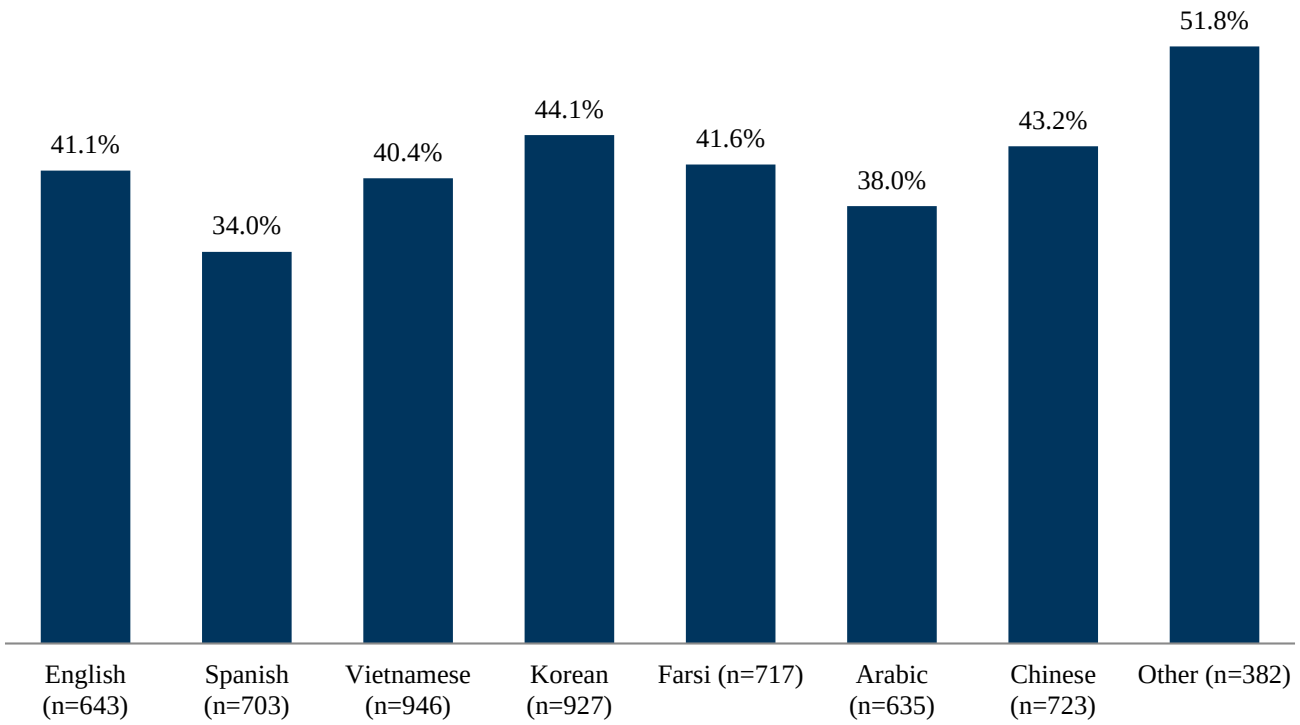
Region:



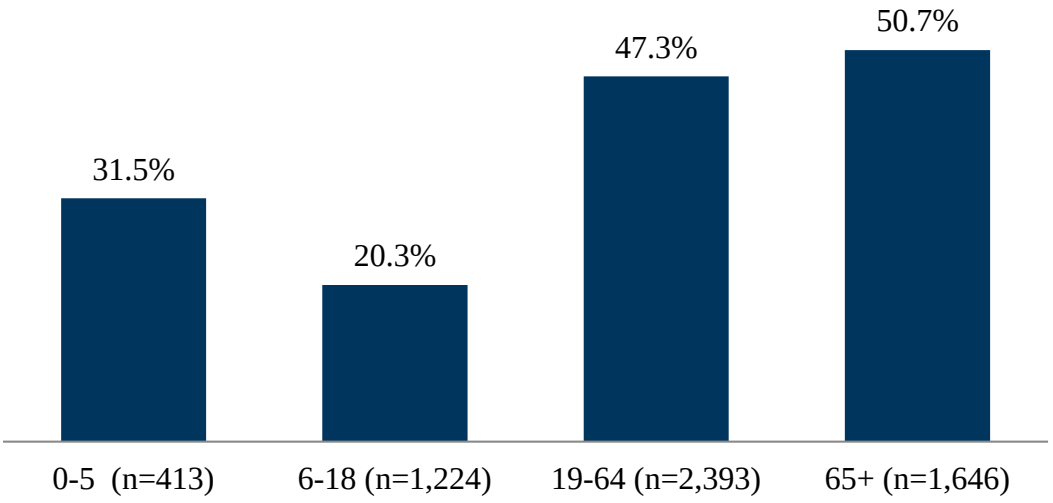
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:



Age Category:



Region:

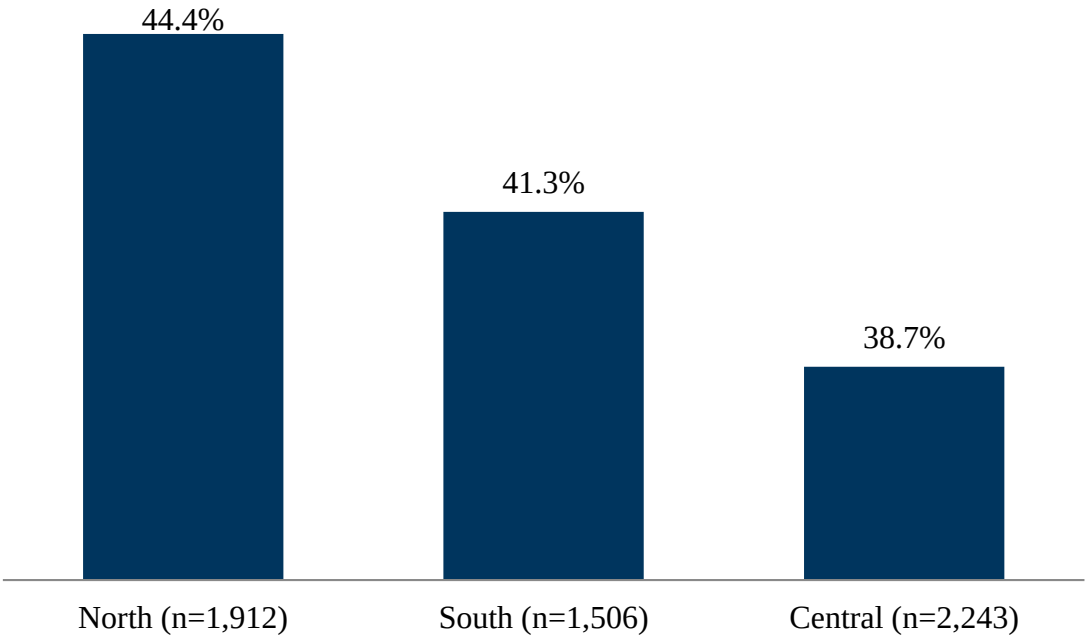


Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]

CalOptima Language:

CalOptima Language	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
English	43.8%	28.3%	6.6%	8.1%	258
Spanish	39.5%	17.6%	4.9%	12.2%	205
Vietnamese	26.6%	15.7%	5.0%	13.0%	338
Korean	64.2%	35.3%	4.1%	5.1%	391
Farsi	53.1%	23.8%	5.1%	8.1%	273
Arabic	62.9%	16.3%	1.8%	11.8%	221
Chinese	40.6%	21.1%	7.7%	14.1%	298
Other	33.1%	23.2%	5.5%	12.7%	181

Age Category:

CalOptima Age Category	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
0-5 (Children)	19.5%	23.7%	3.4%	14.4%	118
6-18 (Children)	34.7%	25.6%	1.8%	15.1%	219
19-64 (Adults/MCE)	52.7%	27.3%	4.1%	9.0%	1,062
65+ (Older Adults)	19.5%	23.7%	3.4%	14.4%	766

[17] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

[18] Only reported those who have not seen a dentist within the past 12 months.

Region:

CalOptima Region	Cost	Don't have/know dentist	No transportation	Don't know	n
	%	%	%	%	
North	48.9%	22.3%	5.5%	9.9%	798
South	51.6%	28.2%	4.6%	9.4%	585
Central	39.2%	20.9%	5.2%	11.3%	776

Exhibit 26. Days per week member had at least one drink of alcoholic beverage during the past 30 days [19]

CalOptima language:

CalOptima Language	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
English	71.7%	19.6%	4.0%	2.0%	2.7%	403
Spanish	83.5%	10.4%	1.3%	0.9%	3.9%	230
Vietnamese	81.3%	10.7%	1.9%	1.8%	4.3%	738
Korean	77.1%	15.5%	3.0%	1.5%	2.9%	593
Farsi	74.8%	19.3%	1.2%	0.2%	4.4%	497
Arabic	87.6%	4.5%	0.6%	0.8%	6.5%	355
Chinese	84.9%	8.0%	1.2%	0.6%	5.4%	503
Other	83.7%	7.7%	1.6%	1.3%	5.8%	312

Age Category:

CalOptima Age Category	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
19-64 (Adults/MCE)	78.7%	13.0%	2.3%	1.0%	4.9%	2,163
65+ (Older Adults)	82.2%	11.4%	1.4%	1.4%	3.5%	1,468

[19] Only reported those who are 18 years or older.

Region:

CalOptima Region	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
North	81.1%	11.9%	1.2%	1.5%	4.3%	1,156
South	79.5%	14.5%	1.8%	0.7%	3.5%	1,000
Central	79.7%	11.4%	2.5%	1.3%	5.1%	1,465

January 2018

CalOptima Member Survey Data Book:

Weighted Population Estimates

harder + co | community research

CalOptima A Public Agency Better. Together.

Navigating the Healthcare System

Exhibit 27. Percent who report at least one person as their doctor (n=5,749)

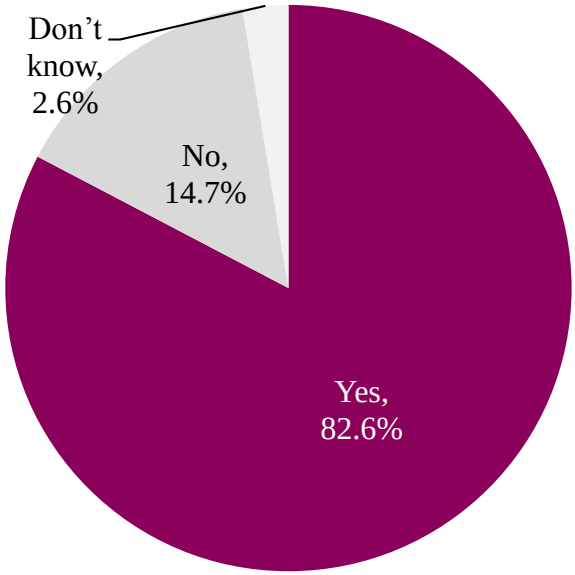


Exhibit 28. Where respondents go to see their doctor (n=5,743)

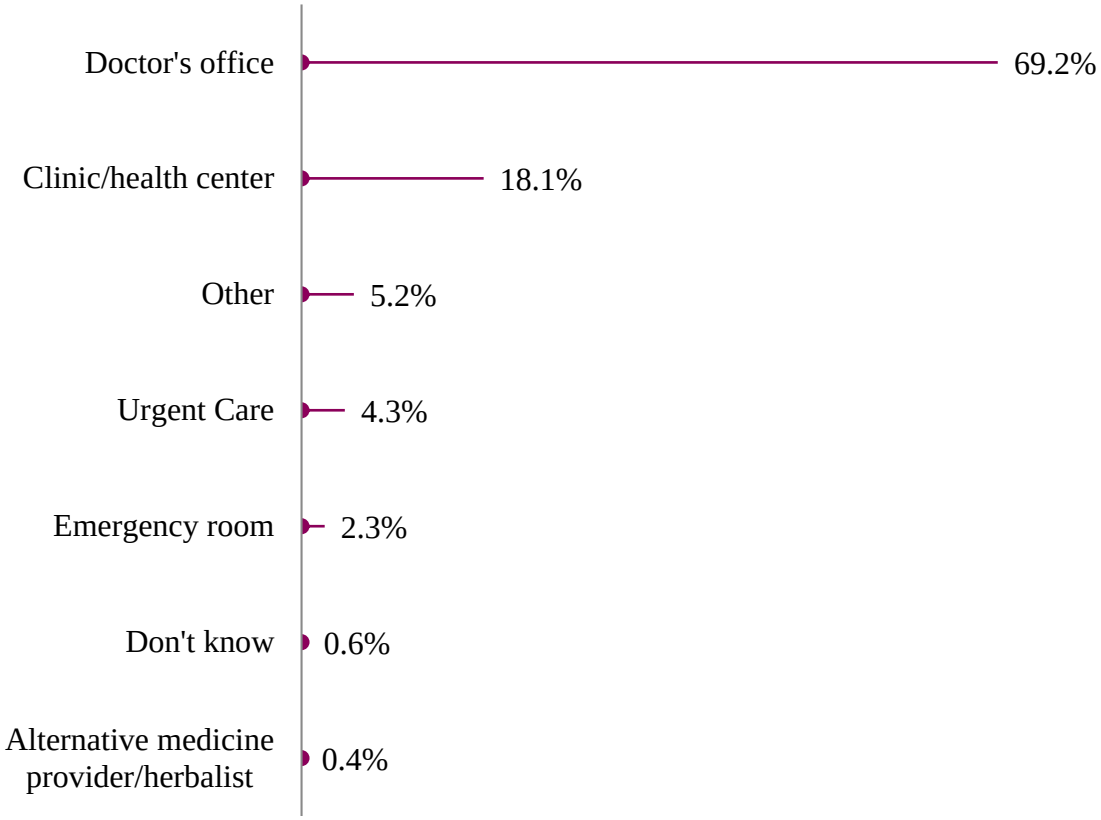


Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

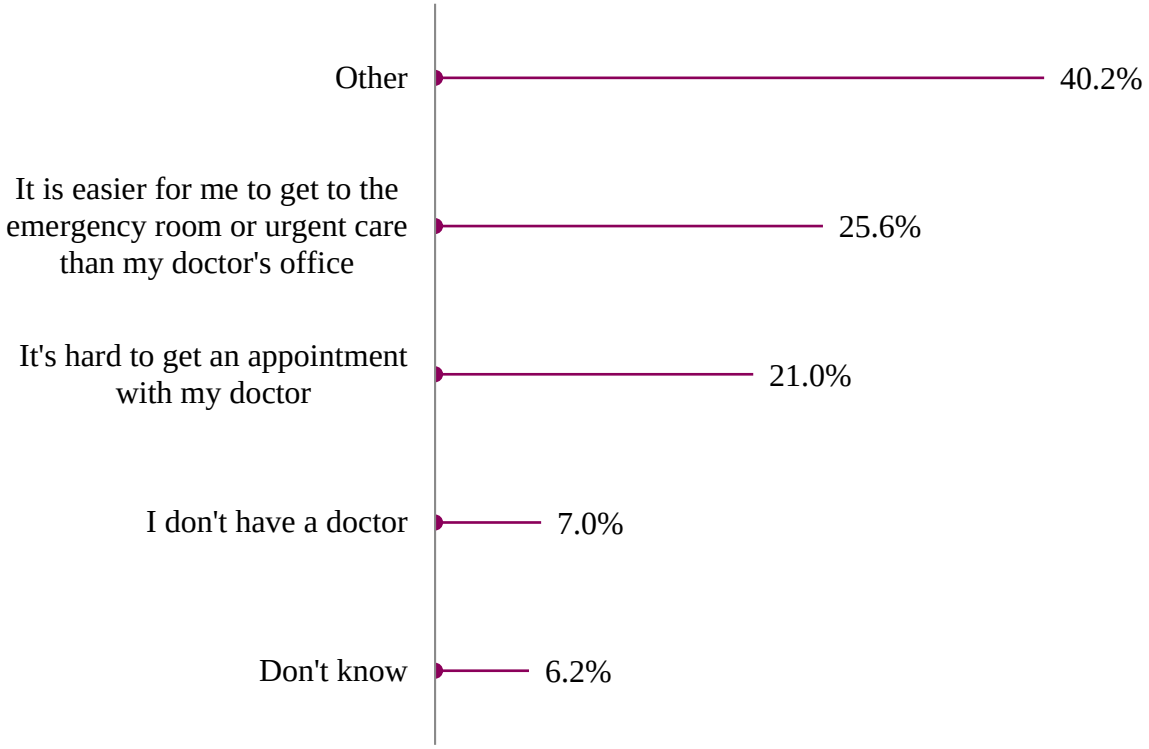


Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]

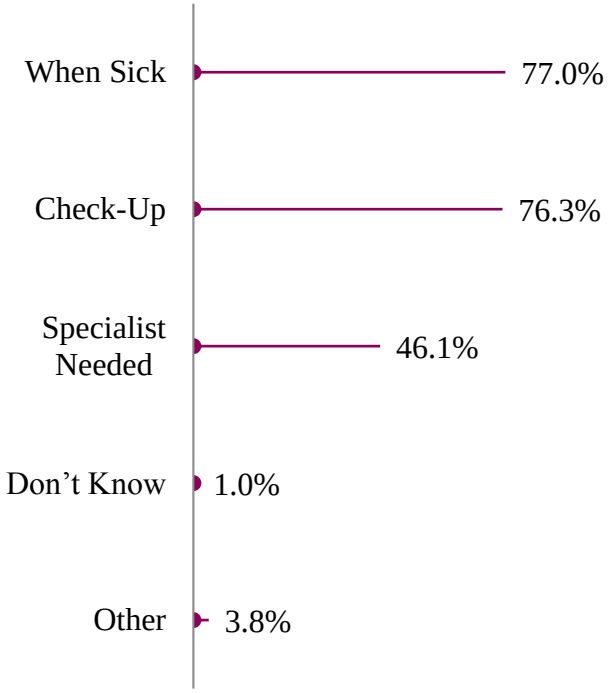
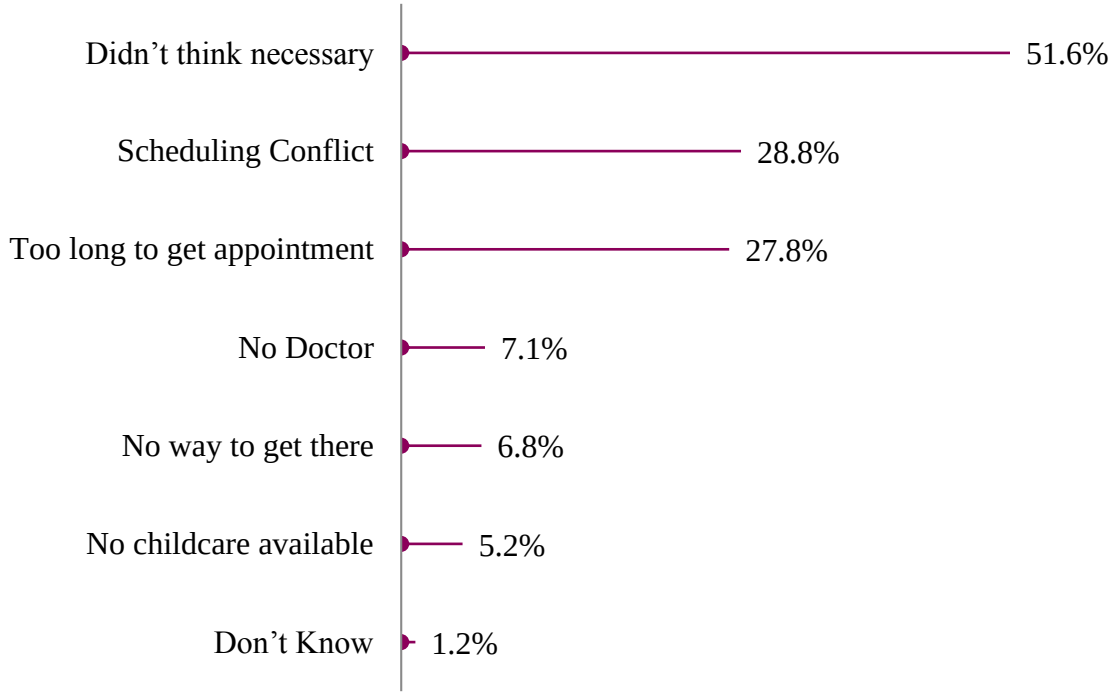


Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]



[20] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[21] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 32. When do members make an appointment to see a specialist (n=5,590)[22]

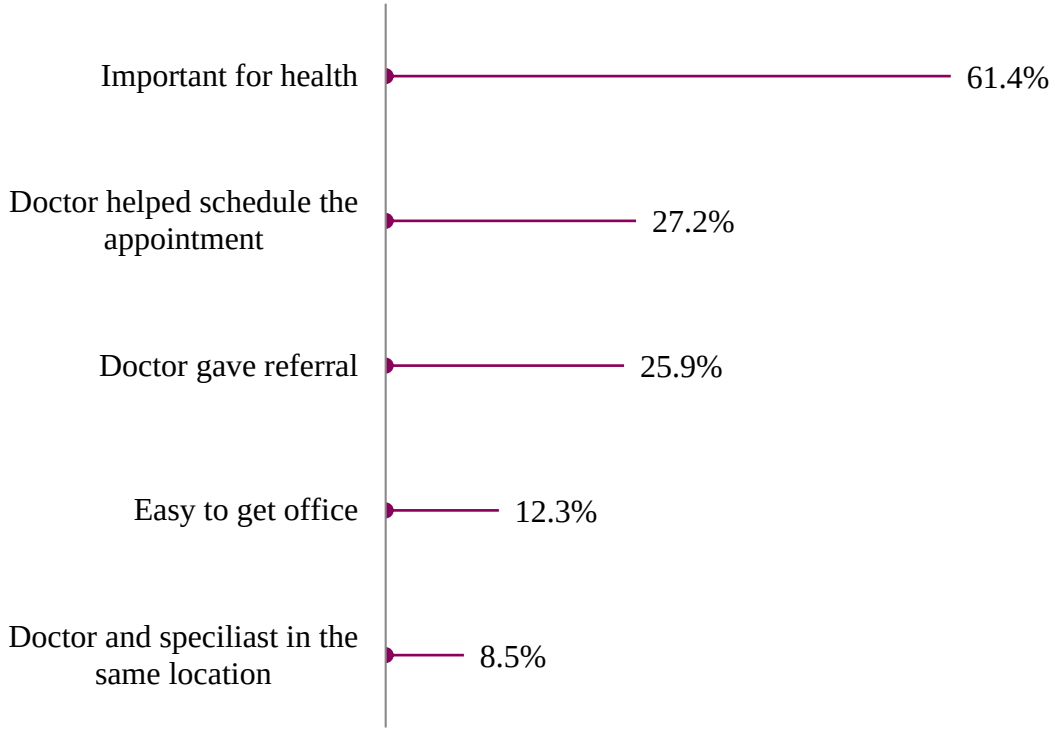
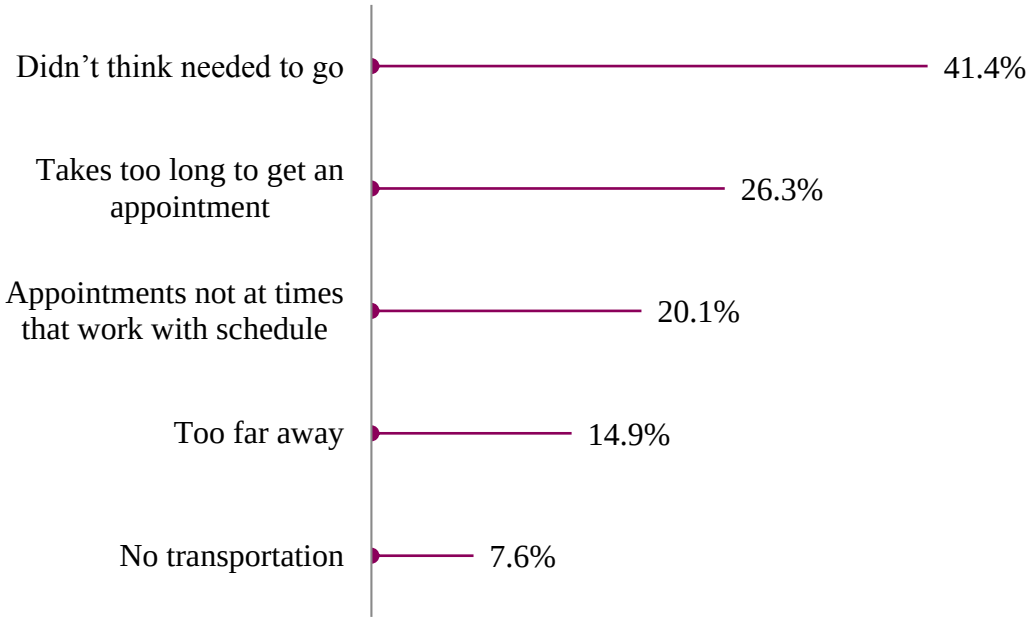
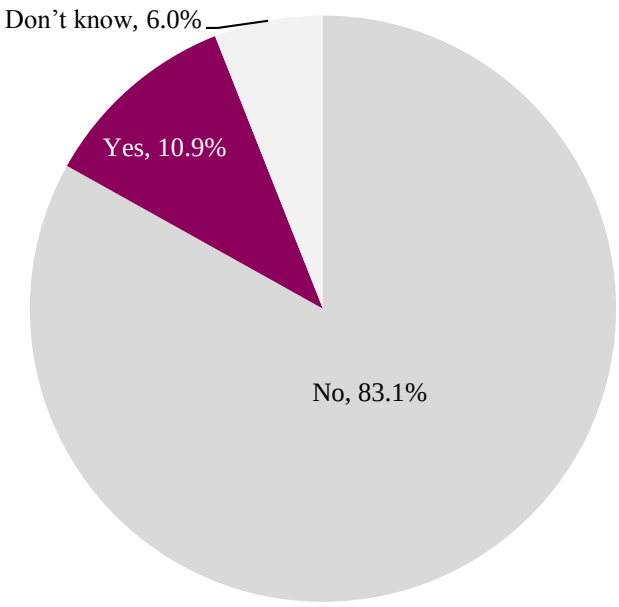


Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]



[22] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[23] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 34. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor (n=4,955)



Social and Emotional Well-Being

Exhibit 35. Percent of members who indicated they needed to see a mental health specialist (n=5,723)

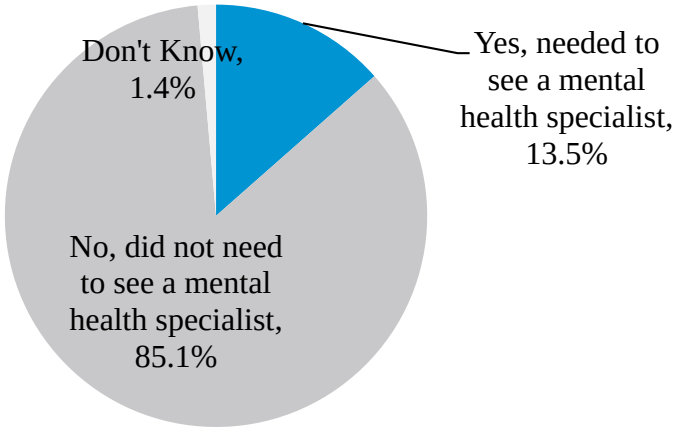


Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)

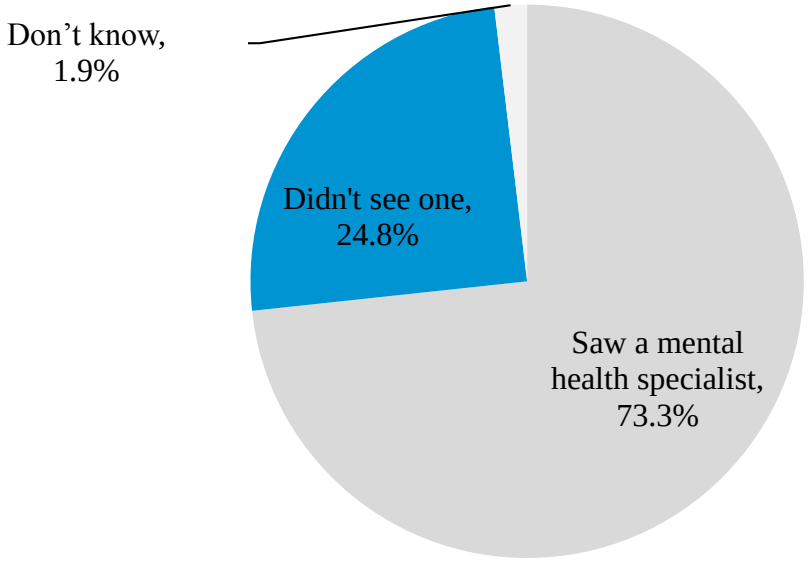


Exhibit 37. Reasons why members didn't see mental health specialist[24]

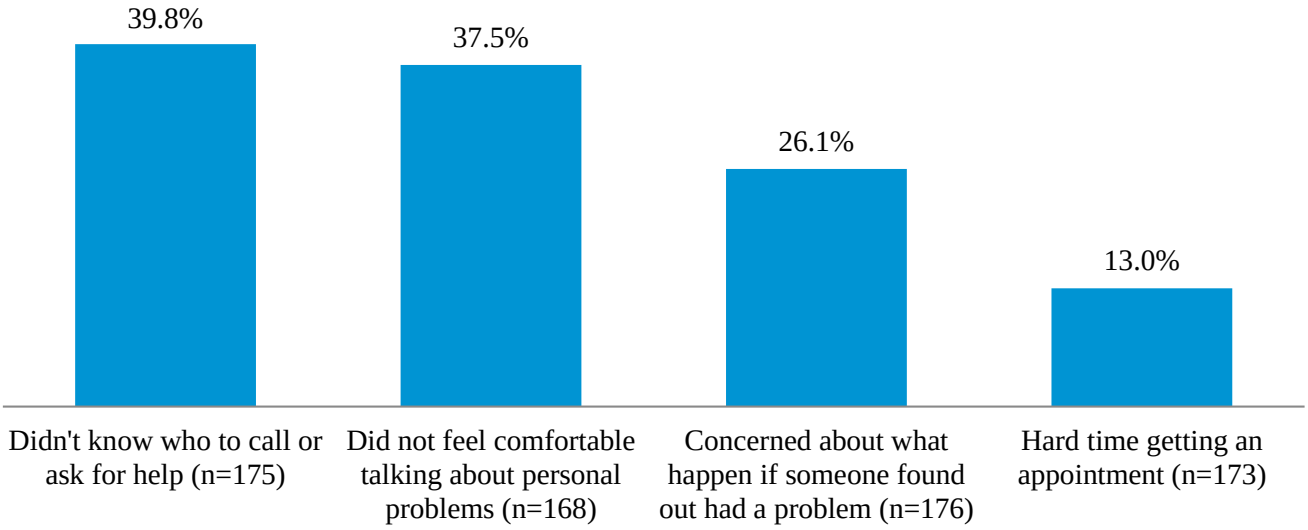
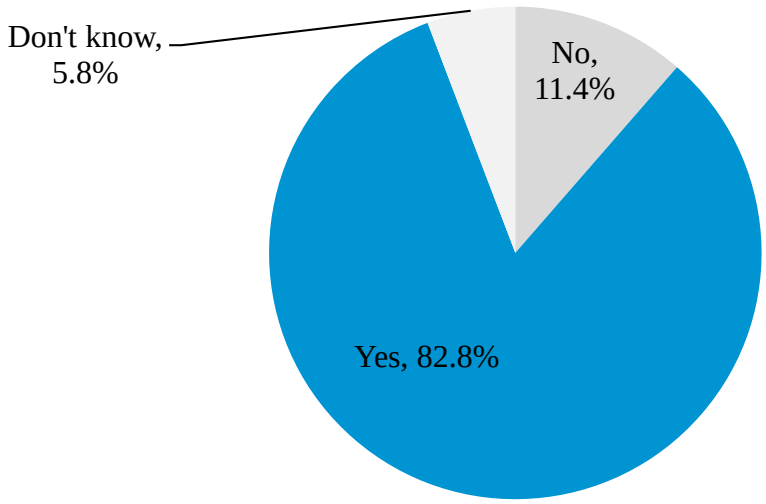


Exhibit 38. Percent of members who can share their worries with family members (n=5,670)



[24] Among those who indicated that they needed to see a mental health specialist but did not see one.

Social Determinants of Health

Exhibit 39. Percent of members who needed help with basic needs in the past 6 months:

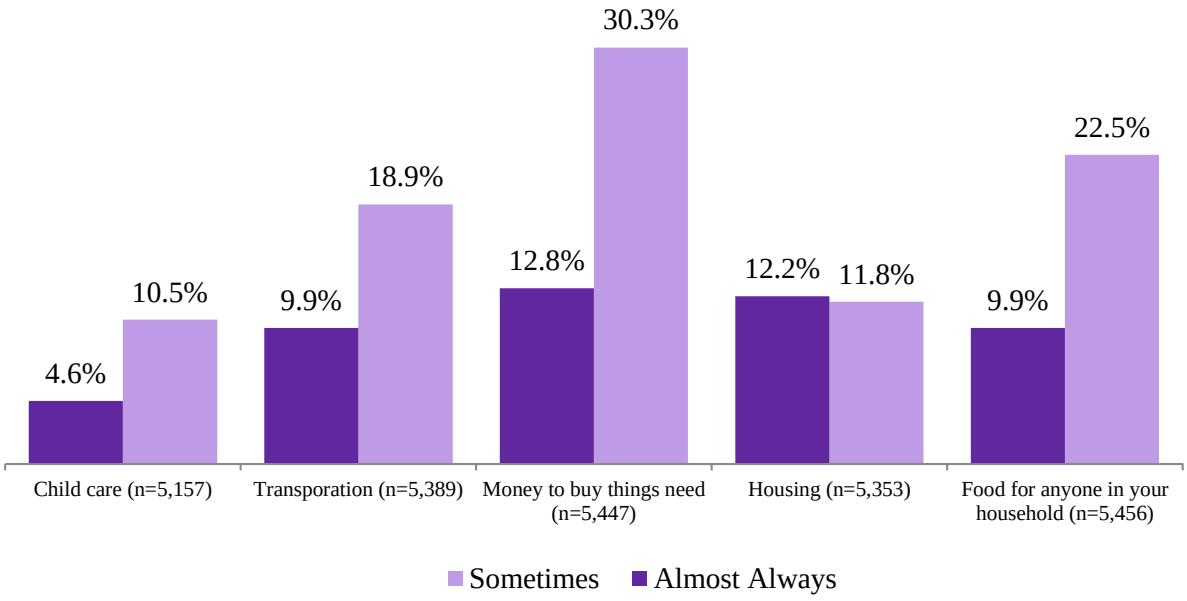


Exhibit 41. Percent of members who receive public benefits (n=5,117):

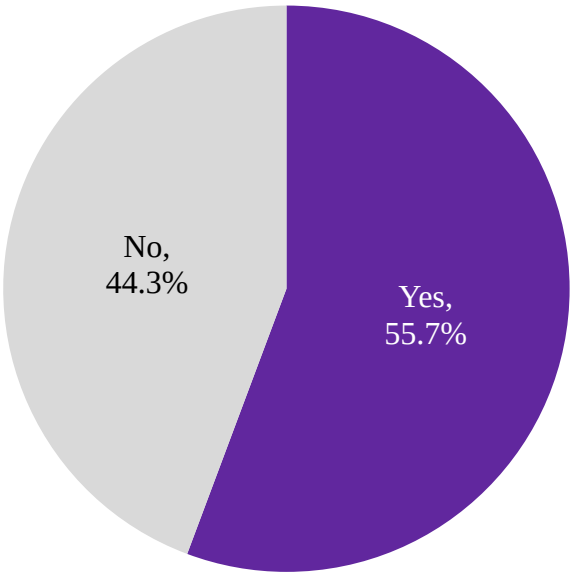
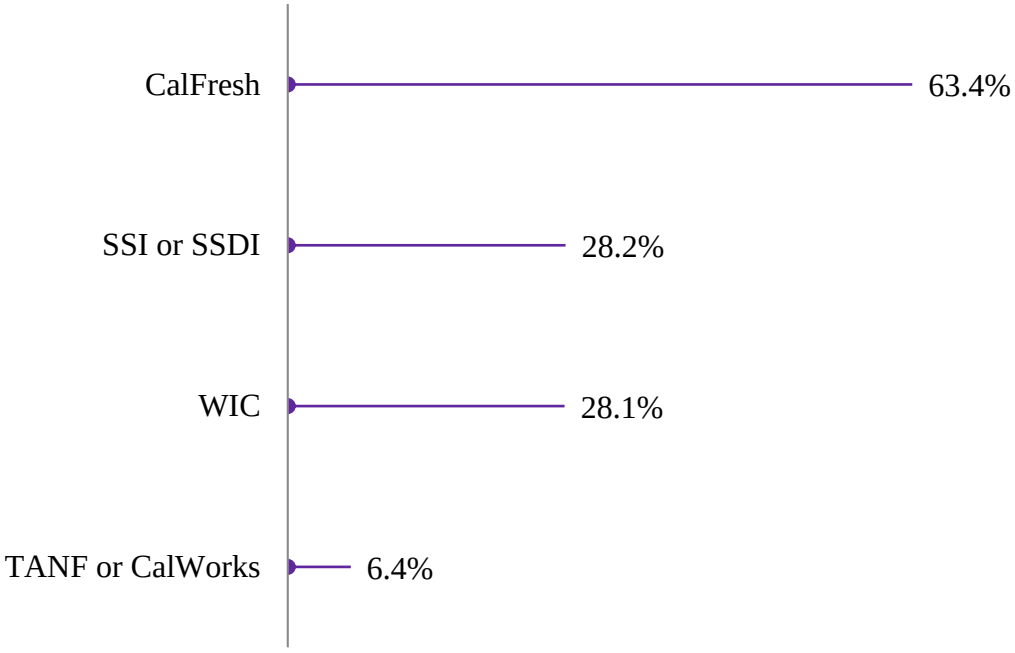


Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:

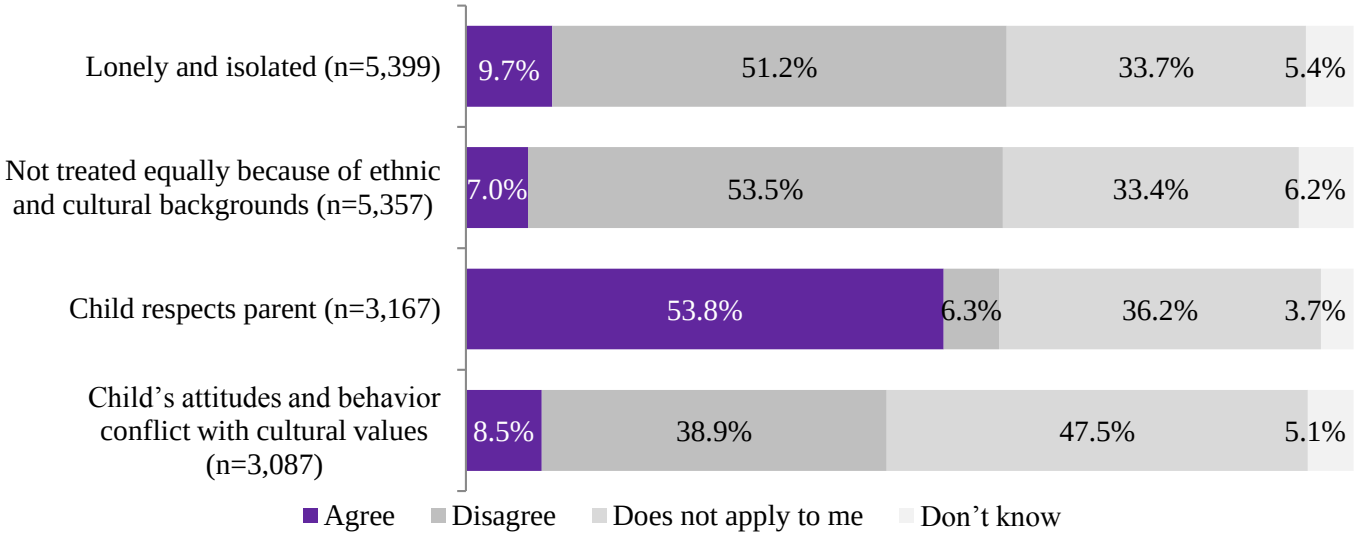


[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

Exhibit 43. Personal activities members participant in:

	Once a week	Once a month	Once in the last 6 months	Never	n
Care for a family member	36.2%	5.6%	5.1%	53.1%	5,209
Fun with others	61.9%	17.0%	6.6%	14.6%	5,396
Volunteer or Charity	16.4%	14.2%	17.3%	52.1%	5,288
Physical fitness	68.4%	10.2%	4.8%	16.7%	5,393
Attend religious centers	48.7%	11.1%	10.8%	29.4%	5,470
Get enough sleep	83.5%	5.8%	1.1%	9.6%	5,119
Enough time for self	77.4%	10.6%	3.1%	8.8%	5,209
Enough time for family	81.5%	8.5%	3.1%	6.9%	5,274
Gambling activities	0.9%	0.8%	4.8%	93.5%	5,378

Exhibit 44. Feelings towards community and home enviroment[26]:



[26] Only reported for those over 18 years old for "Child respects parent" and "Child's attitudes and behavior conflict with cultural values."

Exhibit 45. How well members speak English (n=5,549)

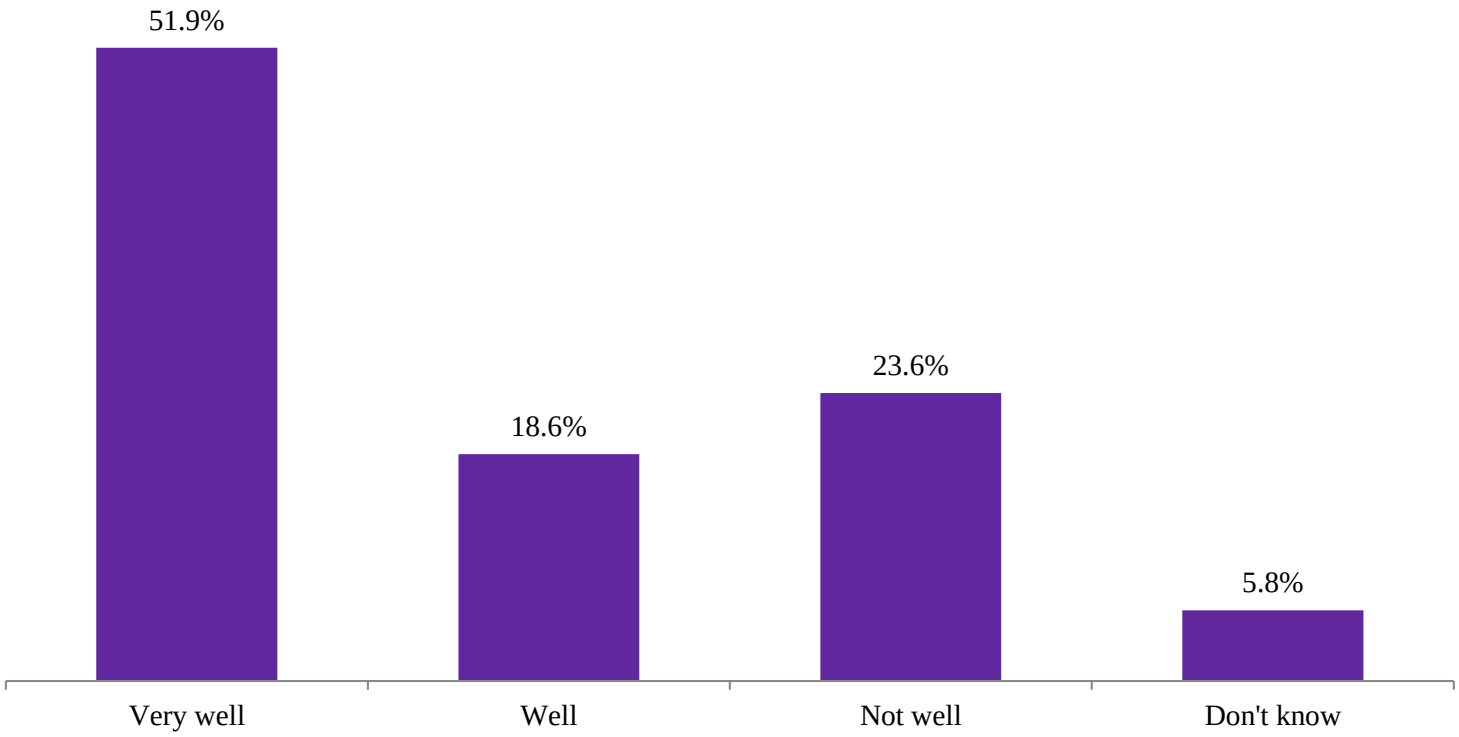


Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]

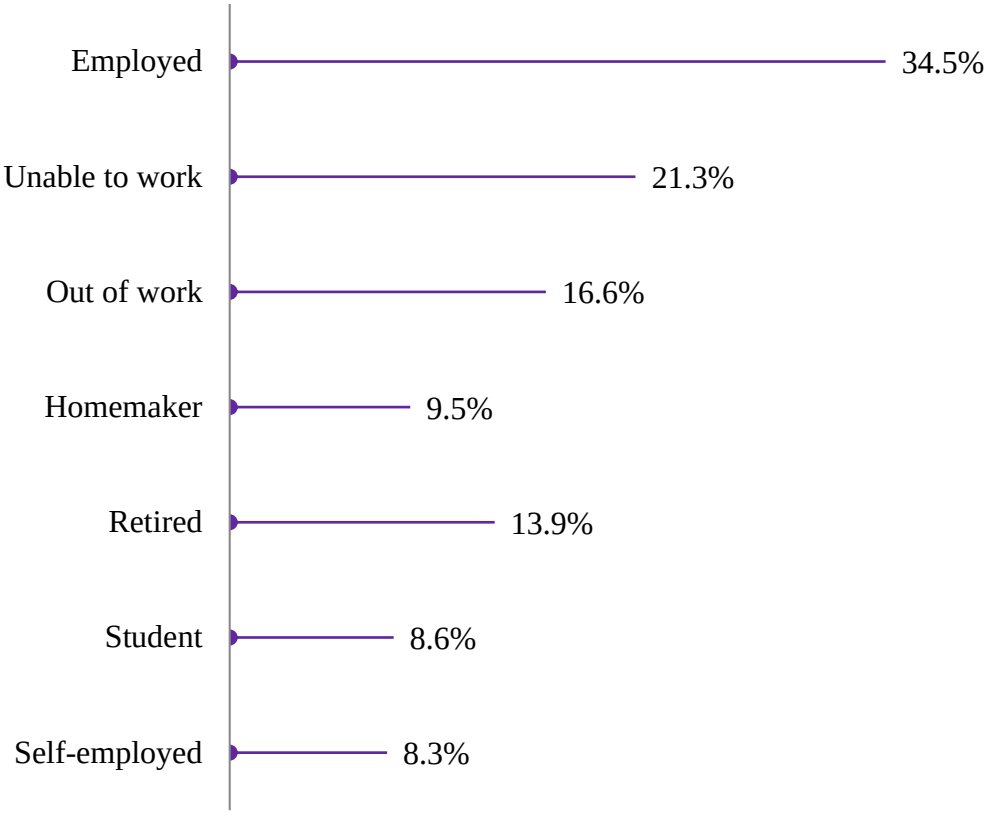
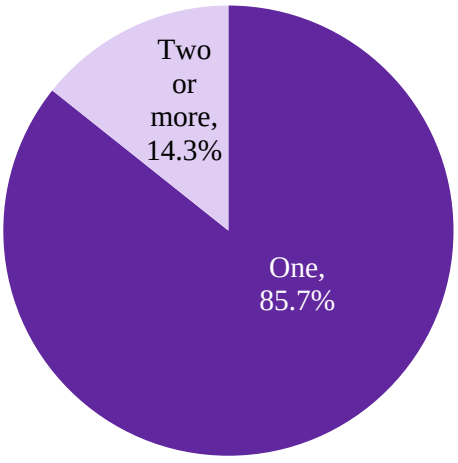
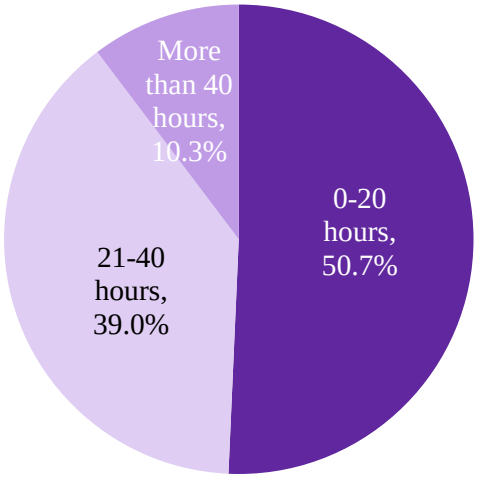


Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]

Number of jobs members have



Number of hours that members work each week



[27] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[28] Only reported the members who are over 18 years old.
[29] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

Exhibit 48. Members' living situation (n=5,590)

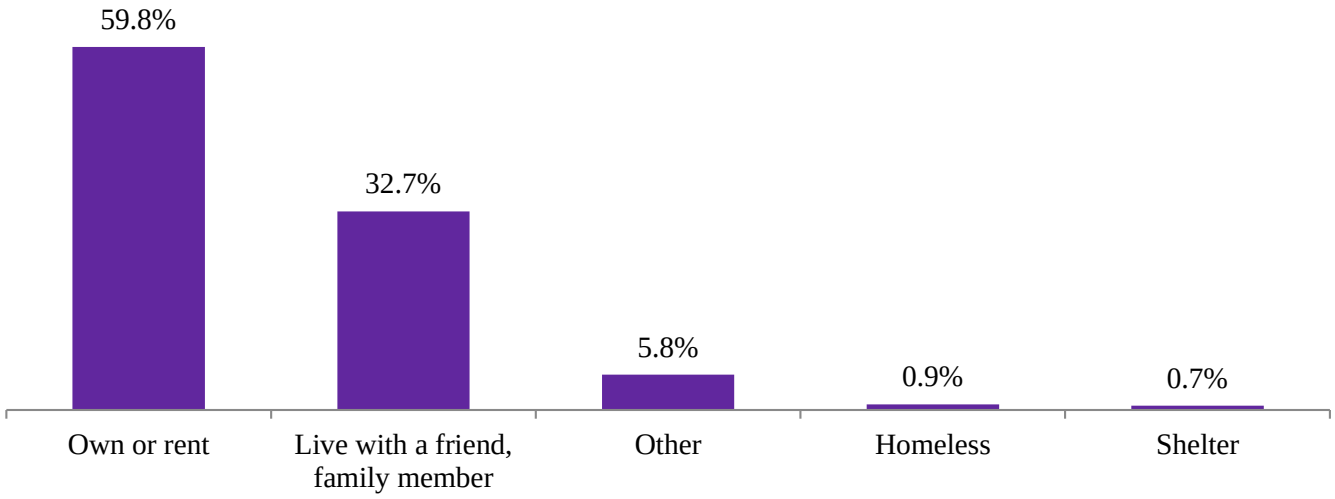
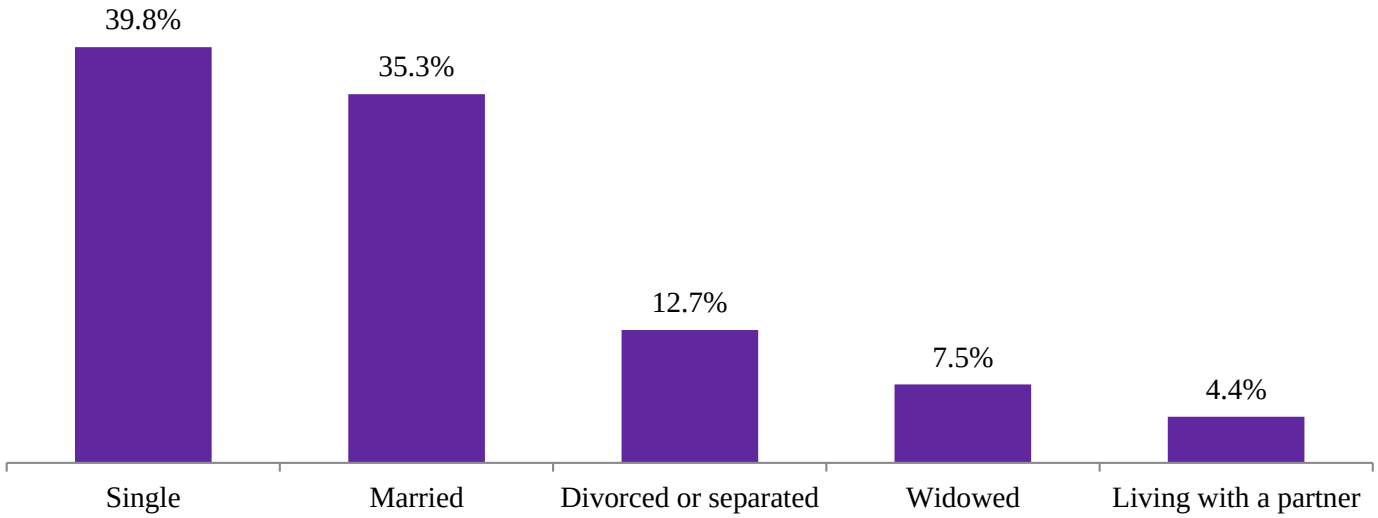


Exhibit 49. Marital status of members (n=3,271)[30]



[30] Only reported those who are over 18 years old.

Exhibit 50. Percent of members who were born in the United States (n=5,599)

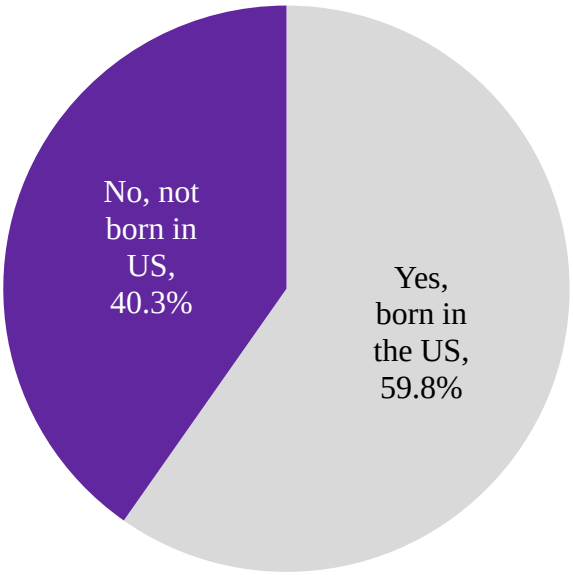
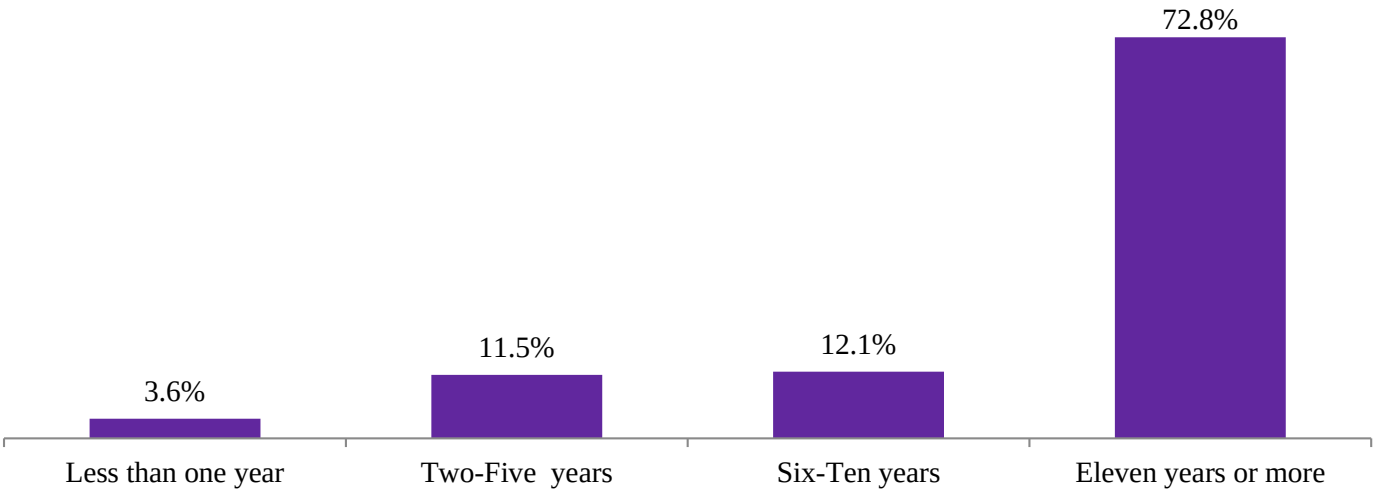


Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]



[31] Of those who were born outside of the U.S.

Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

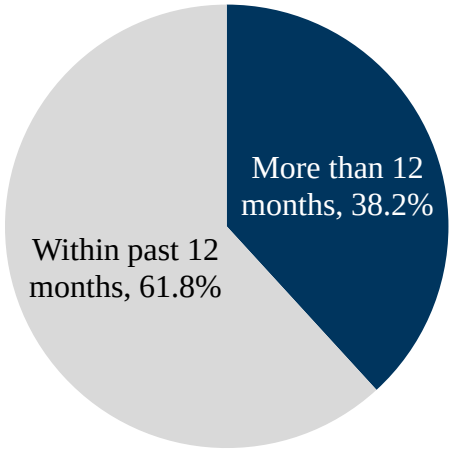
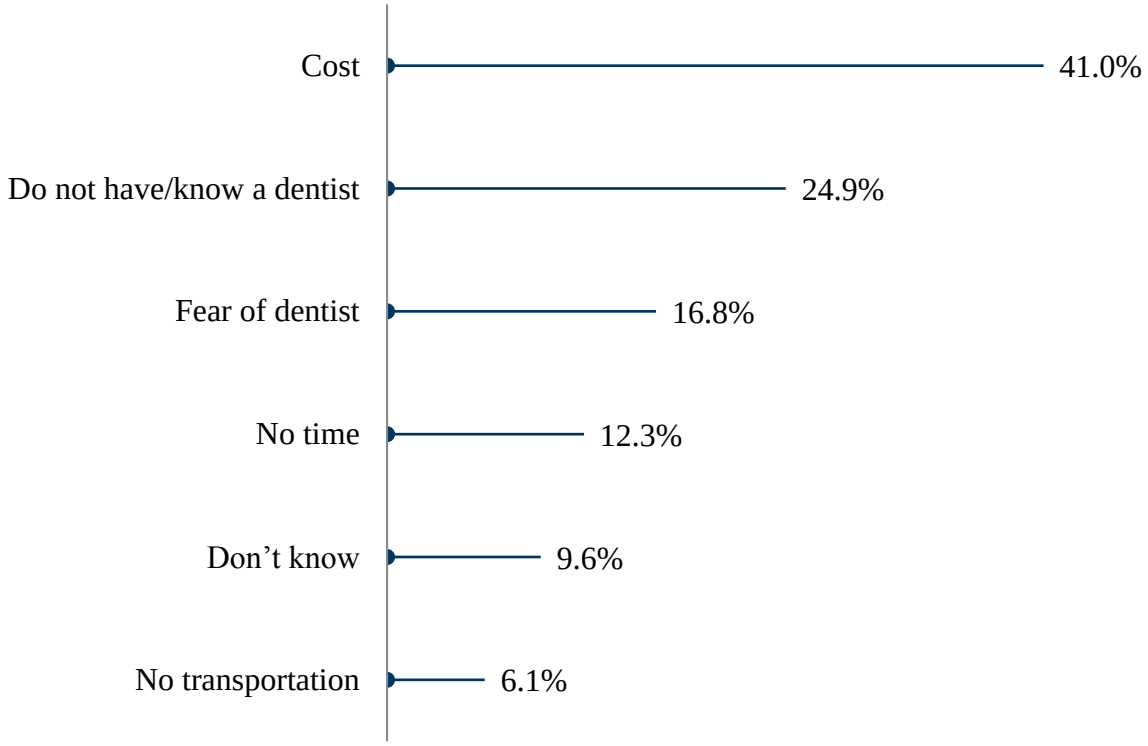
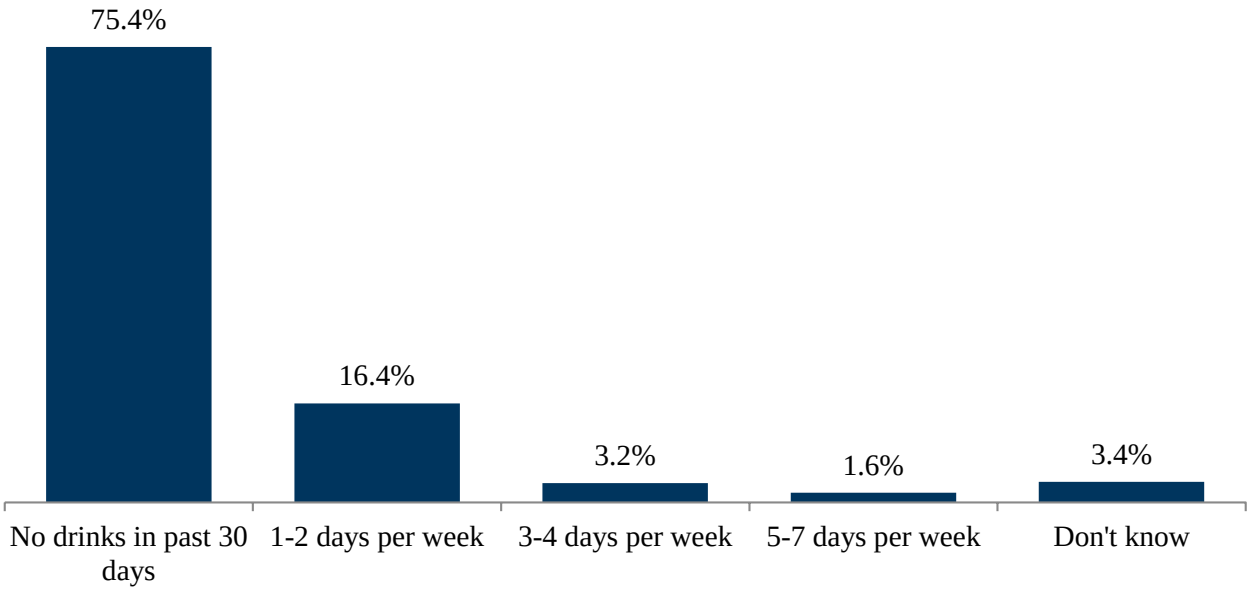


Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]



[32] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[33] Only reported those who have not seen a dentist within the past 12 months.

Exhibit 54. Days per week member had at least one drink of alcoholic beverage during the past 30 days (n=3,083)[34]



[34] Only reported those who are 18 years or older.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

41. Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

Authorize the release of Requests for Information (RFI) for the eight board-approved categories identified by the CalOptima Member Health Needs Assessment to develop specific Scopes of Work for full Requests for Proposal (RFP).

Background

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to award approximate $14.4 million in IGT 5 funds.

CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders.

At the February 1, 2018 Board of Directors meeting, staff presented the results and Executive Summary of the MHNA as well as requested authority to release Requests for Proposal (RFP) for community grants. From the information gathered, the MHNA identified eight board-approved categories as needs in the community. The eight board-approved categories include:

1. Expand Access to Mental Health Services for Adults
2. Expand Access to Mental Health and Socialization Services for Older Adults
3. Expand Access to Mental Health/Developmental Services for Children Ages 0-5
4. Expand Access to Nutrition Education and Fitness Programs for Children and their Families
5. Increase Medi-Cal Benefits Education and Outreach
6. Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health
7. Expand Access to Adult Dental Services
8. Expand Access to Children's Dental Services

Approval to release the RFPs was unanimous by the Board of Directors.

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Discussion
In preparation for the release of the community grant RFPs, staff conducted a review of the descriptions for each of the eight categories identified by the MHNA. Staff recognized a need to narrow and better define a more precise and definitive Scope of Work (SOW) for each category. The specific SOWs for the RFPs will be developed based on the responses received from the RFI process. The RFI responses will be evaluated to select innovative ideas for services and programs to address the needs of CalOptima members. Staff will review the RFI responses and develop full RFPs so that interested community-based organizations, public agencies and other eligible entities can submit a proposal for consideration. More than one idea per category may be selected from the RFI responses and developed into a full RFP.

Staff is requesting authority to release RFIs for the eight board-approved categories that were identified through the MHNA. Staff will return to the Board for approval of the scopes of work developed in conjunction with the RFI and to release the RFPs.

Fiscal Impact
There is no fiscal impact to CalOptima's general operating budget.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima staff plans to work with our provider and community partners to address gaps in health care services for CalOptima members.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Board Action dated February 1, 2018, Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

Member Health Needs Assessment

Board of Directors Meeting
February 1, 2018

Cheryl Meronk
Director, Strategic Development

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Member Health Needs Assessment

A better study offering deeper insight, leading to a healthier future.

A Better Study

- ➔ More Comprehensive
- ➔ More Engaging
- ➔ More Personal

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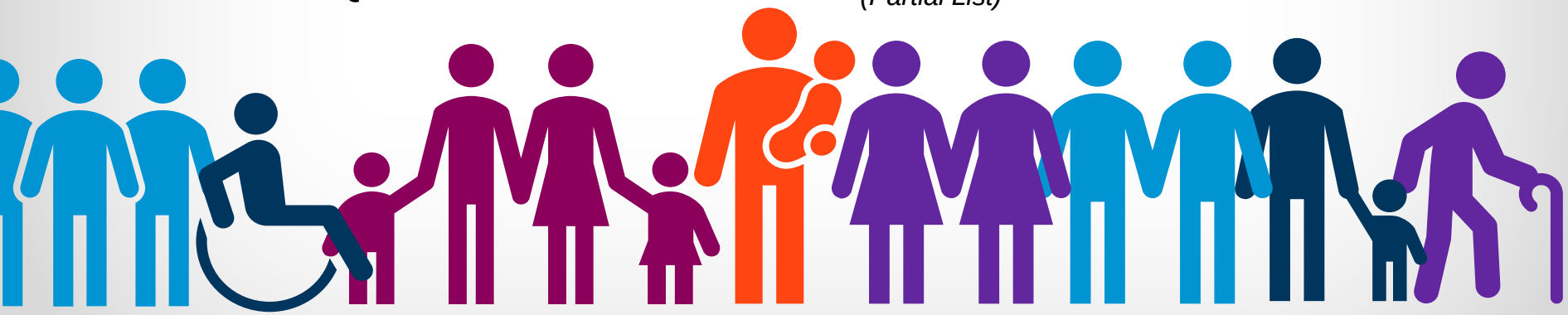
More Comprehensive

- Reached new groups of members whose voices have rarely been heard before
  - Young adults with autism
  - People with disabilities
  - Homeless families with children
  - High school students
  - Working parents
  - New and expectant mothers
  - LGBTQ teens
  - Homeless people in recuperative care
  - Farsi-speaking members of a faith-based group
  - PACE participants
  - Chinese-speaking parents of children with disabilities

(Partial List)



More Comprehensive (Cont.)

- Gathered responses from all geographic areas of Orange County



More Comprehensive (Cont.)

- Probed a broader view of members' lives beyond immediate health care needs
  - Hunger
  - Child care
  - Economic stress
  - Housing status
  - Employment status
  - Physical activity
  - Community engagement
  - Family relationships
  - Mental health
  - Personal safety
  - Domestic violence
  - Alcohol and drug consumption

(Partial List)

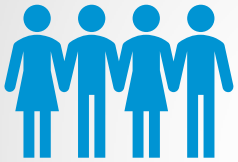


More Comprehensive (Cont.)

- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In the past 12 months, did you have the need to see a mental health specialist?
  - How open are you with your doctor about your sexual orientation?
  - How sensitive are your health care providers in understanding your disability?

(Partial List)

More Engaging: Members



Focus Groups

- 31 face-to-face meetings in the community
- 353 members



Telephone Conversations

- 534 live interviews in members' languages



Mailed Surveys

- Nearly 6,000 surveys returned



Electronic Responses

- More than 250 replied conveniently online

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More Engaging: Member Advocates

- Abrazar Inc.
- Access CA Services
- Alzheimer's OC
- Boys & Girls Club
- The Cambodian Family
- CHOC
- Dayle McIntosh
- La Habra Family Resource Center
- Latino Health Access
- Korean Community Services
- Mercy House
- MOMS Orange County
- OMID
- SeniorServ
- South County Outreach
- State Council on Developmental Disabilities
- Vietnamese Community of OC Inc.

(*Partial List)*

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More Personal

- Met in familiar, comfortable locations at convenient times for our members
  - Apartment complexes
  - Churches
  - Community centers
  - Schools
  - Homeless shelters
  - Recuperative care facilities
  - PACE center
  - Community clinics
  - Restaurant meeting rooms



More Personal (Cont.)

- We spoke their language
  - English
  - Spanish
  - Vietnamese
  - Korean
  - Farsi
  - Chinese
  - Arabic
  - Cambodian
  - Marshallese
  - American Sign Language



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Offering Deeper Insight

- ➔ Barriers to Care
- ➔ Lack of Awareness About Benefits and Resources
- ➔ Negative Social and Environmental Impacts

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Notable Barriers to Care

- Study revealed that members encounter structural and personal barriers to care
  - Structural
    - It can be challenging to get an appointment to see a doctor
    - It takes too long to get an appointment
    - Doctors do not always speak members' languages
    - Interpreter services are not always readily available
    - Doctors lack understanding of members' cultures
  - Personal
    - Members don't think it is necessary to see the doctor
    - Members have personal beliefs that limit treatment
    - Members are concerned about their immigration status
    - Members are concerned someone would find out they sought mental health care

Barriers to Care (Cont.)

Examples

52%

Don’t think it is necessary to see the doctor for a checkup

28%

Takes too long to get an appointment

26%

Concerned someone would find out about mental health needs

41%

Didn’t think it is necessary to see a specialist, even when referred

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Notable Lack of Awareness

- Survey revealed a lack of understanding about available benefits and services
  - 25 percent of members who needed to see a mental health specialist did not pursue treatment
  - 38 percent of members had not seen a dentist in more than a year

- Focus group participants commented frequently about having difficulty regarding certain resources
  - Interpreter services
  - Social services needs
  - Transportation

Lack of Awareness (Cont.)

Examples

40%

Didn’t know who to ask for help with mental health needs

41%

Didn’t see a dentist because of cost (i.e., didn’t know dental care was covered)

25%

Don’t have or know of a dentist

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Negative Social and Environmental Impacts

- Survey revealed significant social and environmental difficulties
  - Lack of well paying jobs and employment opportunities
  - Lack of affordable housing
  - Social isolation due to cultural differences, language barriers or fear of violence
  - Economic insecurity and financial stress
  - Lack of walkable neighborhoods and the high cost of gym programs

Negative Impacts (Cont.)

Examples

32%
Needed help getting food in the past six months

56%
Accessing other public assistance

43%
Needed help to buy basic necessities

29%
Needed help getting transportation

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Negative Impacts (Cont.)

Stakeholder Perspective

> There's a significant issue with improper nutrition. They may not have enough money or the ability to go to the grocery store to buy the right foods. They get what they can, and that's what they eat.
>
> *—Interviewee*

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Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

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Funding

$14.4 Million

Total Available IGT 5 Funds

- **Member Health Needs Assessment results drive funding allocations**

- **Eight Requests for Proposal (RFPs) to expand access to mental health, dental and other care, and outreach/education services**

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RFP 1

Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $5 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category

Adult Mental Health

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RFP 2

Expand Mental Health and Socialization Services for Older Adults

Funding Amount: $500,000

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category

Adult Mental Health

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RFP 3

Expand Access to Mental Health/ Developmental Services for Children 0–5 Years

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Shortage of pediatric mental health professionals
- ✓ Shortage of children's inpatient mental health beds
- ✓ Increase in adolescent depression

Funding Category

Children's Mental Health

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RFP 4

Nutrition Education and Fitness Programs for Children and Their Families

Funding Amount: $1 million

Findings Addressed

- ✓ Healthier food choices can be more expensive, less convenient and less accessible
- ✓ Cultural foods may not be the healthiest options
- ✓ Lack of time and safe places may limit physical activity

Funding Category
Childhood Obesity

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RFP 5

Medi-Cal Benefits Education and Outreach

Funding Amount: $500,000

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits

Funding Category

Supporting the Safety Net

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RFP 6

Expanded Access to Primary Care and Programs Addressing Social Determinants of Health

Funding Amount: $4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Lack of ability to cover basic necessities

Funding Category

Supporting the Safety Net

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RFP 7

Expand Adult Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1.4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Limited dental providers for adults

Funding Category

Supporting the Safety Net

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RFP 8

Expand Access to Children's Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not utilizing covered services
- ✓ Challenging to get an appointment to see a provider

Funding Category

Children's Health

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Moving Forward

- Eight Grant Applications/RFPs
  - Expand access to mental health, dental and other care services
  - Expand access to childhood obesity services regarding nutrition and fitness
  - Support outreach and education regarding social services and covered benefits
- RFPs to be released in March 2018
- Recommended grantees to be presented at June Board meeting

EXECUTIVE SUMMARY
MEMBER HEALTH NEEDS ASSESSMENT

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In summer and fall 2017, more than 6,000 CalOptima members, service providers and community representatives participated in one of the most extensive and inclusive member health needs assessments (MHNA) undertaken by CalOptima in its 20-plus year history. The MHNA provides data critical to ensuring that CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima participates in numerous efforts to assess the health of Orange County's residents and create community-driven plans for improving the health of the Medi-Cal population. Some examples are detailed below.

- The 2013 Orange County Health Profile, produced by the Orange County Health Care Agency, highlighted key health indicators as well as other social, economic and environmental indicators that impact health conditions in groups of people based on economics, race, ethnicity, gender, age and geography.
- The 2016 Orange County Community Indicators Report tracked and analyzed Orange County's health and prosperity on a myriad of issues.
- The 2017 Conditions of Children in Orange County Report offered a comprehensive and detailed summary of how children in Orange County fair in the areas of health, economic well-being, educational achievement, and safe homes and communities.
- CalOptima's Group Needs Assessment, conducted every five years with annual updates in between, identifies members' needs, available health education, cultural and linguistic programs, and gaps in services.

When combined, these assessments provide a broad picture of important health information in Orange County. However, they do not focus specifically on Medi-Cal beneficiaries or on ethnic and linguistic minorities within this population, whose health needs are at the core of CalOptima's mission. For this reason, CalOptima undertook this comprehensive MHNA, summarized on the following pages.

By the Numbers

5,815
Surveys

31
Focus Groups

24
Stakeholder Interviews

21
Provider Surveys

10
Languages

Birth–101
Years of Age

CalOptima's comprehensive MHNA is an innovative collaboration that builds upon existing data-gathering efforts and takes them a step further. The study was designed to be a more comprehensive assessment, using engaging methods that resulted in a much more personal experience for our members and the community. The MHNA captures the unique and specific needs of Medi-Cal beneficiaries from an array of perspectives, including providers, community leaders and, most importantly, the members themselves. As a result, this in-depth study offers actionable recommendations for consideration by the CalOptima Board of Directors and executive leadership.

The MHNA was designed to help CalOptima identify:

1. Unique needs and challenges of specific ethnic communities, including economic, social and environmental stressors, to improve health outcomes

2. Challenges to health care access and how to collaborate with community-based organizations and providers to address these barriers

3. Member awareness of CalOptima services and resources, and effective strategies to increase awareness as well as disseminate information within target populations

4. Ways to leverage outreach efforts by partnering with community-based organizations on strategic programs

Our Partners

To guide the direction of the study, CalOptima established an MHNA Advisory Committee made up of community-based representatives. The committee then engaged CalOptima staff and Harder+Company Community Research (Harder+Company), in partnership with the Social Science Research Center (SSRC) at California State University, Fullerton. A summary of their qualifications to participate in this extensive effort is below.

Harder+Company was founded in 1986 and works with philanthropic, nonprofit and public-sector clients nationwide to reveal new insights about the nature and impact of clients' work. Harder+Company has a deep commitment to lifting the voices of marginalized and underserved communities — and working across sectors to promote lasting change. In addition, Harder+Company offers extensive experience working with health organizations to plan, evaluate and improve services for vulnerable populations, along with deep experience assisting hospitals, health departments and other health agencies on a variety of efforts, including conducting needs assessments, engaging and gathering meaningful input from community members, and using data for program development and implementation.

SSRC was established in 1987 to provide research services to community organizations and research support to university faculty. The center's primary goal is to assist nonprofit and tax-supported agencies and organizations to answer research questions that will lead to improved service delivery and public policy. The SSRC conducts surveys, evaluation research and other applied research activities to meet its clients' information needs. The center conducts multilingual telephone surveys from its 24-station computer-assisted telephone interviewing lab, as well as web-based, mailed and face-to-face surveys. In the past 10 years, SSRC has successfully completed 200 telephone survey projects using a variety of sample designs in diverse areas of focus, such as health care, public safety, education, workforce development and pregnancy prevention.

harder + co | community research

CALIFORNIA STATE UNIVERSITY FULLERTON

Due to strong partnerships with the community, the 2017 MHNA engaged members who may be hard to reach. We are proud that our efforts included:

- Young adults on the autism spectrum
- People with disabilities
- Homeless families and children
- High school students
- Working parents
- New and expectant mothers
- LGBTQ teens
- Farsi-speaking members of faith-based groups
- PACE participants
- Chinese-speaking parents of children with disabilities

More Comprehensive

To represent CalOptima's nearly 800,000 members, an in-depth analysis was performed to uncover their unique needs and challenges. An oversampling was thoughtfully incorporated in the calculation of responses needed to achieve a true statistical representation of the Orange County Medi-Cal population. For the mailed survey, more than 42,000 members were selected within a specific sampling frame that included language, age range and region.

With the oversampling, the aim was to collect 4,000 responses with targets for each subgroup. The final data collection results were far beyond the goal in every subgroup. More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

The assessment gathered responses from all geographic areas of Orange County, across all age groups and 10 languages. Additionally, the assessment reached new groups of members whose voices have rarely been sought out or heard before, such as young adults with autism, people with disabilities and homeless families with children.

Ultimately, the assessment concentrated on the underlying social determinants of health that have been recognized as factors that impact the health of individuals. The MHNA probed a broader view of members' lives beyond immediate health care needs to explore issues related to:

- ☑ Hunger
- ☑ Child care
- ☑ Economic stress
- ☑ Housing status
- ☑ Employment status
- ☑ Physical activity
- ☑ Community engagement
- ☑ Family relationships
- ☑ Mental health
- ☑ Personal safety
- ☑ Domestic violence
- ☑ Alcohol and drug use

More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

More Engaging

The MHNA used a mixed-methods approach to engage members who generally have been underrepresented in previous assessments as well as community stakeholders who work directly with the Medi-Cal population. The data collection effort was extensive, incorporating both qualitative and quantitative methods and going beyond previous processes in Orange County. The mixed-methods approach consisted of the following:

Member Survey

5,815 members completed an in-depth 50-question survey that was available in each of CalOptima's seven threshold languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic. As described further below, three additional languages that are less common in Orange County were also incorporated to ensure the assessment was comprehensive. Most surveys were completed and returned via mail (86 percent), with 9 percent completed via telephone and 5 percent online. Telephone calls were made to reach members who were homeless or more transient and may not have a permanent address. An online survey was offered for members' convenience.

Provider Survey

An online survey of 20 questions was sent to a broad sample of providers in CalOptima's network to seek insight on the challenges that members face. Providers identified what they perceive as the top problems for Medi-Cal members as well as barriers for these members in accessing health care. There were 21 network or physician medical groups that completed the provider survey.

Focus Groups

31 focus groups were conducted with members in partnership with community-based organizations across Orange County. Focus groups allowed for face-to-face conversations with members in comfortable and familiar environments, which helped to foster organic, open-ended discussions where members felt safe to share their thoughts. The discussions were conducted in CalOptima's seven threshold languages, as well as Cambodian, Marshallese and American Sign Language. Focus group conversations covered numerous key topics, including quality of life, community assets, barriers to accessing care, violence, behavioral health, chronic disease, and health practices, such as healthy eating and active living.

Key Stakeholder Interviews

24 leaders from community-based organizations participated in the interviews. Those chosen for the study have direct interactions with Medi-Cal members or serve as advocates for Orange County's vulnerable population. Interviews focused on key health issues facing Medi-Cal members, the provision of culturally competent services, and the social determinants of health, such as economic and environmental factors.

In the spirit of collaboration, individuals and groups in the community came together in a remarkable way to demonstrate their dedication to CalOptima members. Countless hours were spent planning, engaging and meeting with members. For example, in addition to serving as stakeholder interviewees, many of CalOptima's community partners reached out to members to encourage them to respond to the surveys, and they also hosted and recruited members to focus group meetings. Community organizations were invaluable in helping members feel comfortable with the process and in providing another view into members' lives. The engagement of community partners and member advocates was instrumental in the success of the MHNA.

More Personal

The MHNA aimed to give CalOptima members a more personal experience by hosting focus group conversations in familiar locations at convenient times, often evenings and weekends. These settings were intentionally selected based on members' comfort levels. Focus groups were also held at specific times to ensure that members could have their voices heard without having to miss work, school or other obligations. Focus groups were conducted in 10 languages enabling members to respond in their preferred spoken language.

Focus groups were held at:

- Apartment complexes
- Churches
- Community centers
- Schools
- Homeless shelters
- Recuperative care facilities
- PACE center
- Community clinics
- Restaurant meeting rooms

Methods

With a strong focus on engaging a representative sample of CalOptima members, Harder+Company and SSRC developed the sample frame to capture a breadth of perspectives as well as focus on the specific needs of key populations. Although the purpose of the MHNA was to assess the needs of Medi-Cal members in Orange County overall, Harder+Company and SSRC sought to gain a better understanding of the needs of CalOptima's non-English speakers by purposefully oversampling all seven subgroups. The oversampling of members designated as speaking one of the seven threshold languages ensured that CalOptima and community stakeholders can be 95 percent confident that the true population parameters for any particular subgroup will fall between +/- 5 percent of the observed sample estimate.

At more than 5,800 members, the survey response far exceeded the target number of respondents in the sampling frame. The robust response was due to a comprehensive data collection plan that included communication with members and partners in advance of sending the survey, reminder phone calls and multilingual computer-assisted telephone interviewing for members preferring to respond by phone.

Survey data was entered, monitored and quality checked by SSRC before being exported for analysis by Harder+Company. All variables were screened to determine the amount of missing data, and basic frequencies were initially computed for each question by language, region and age. To adjust for the oversampling built into the sampling frame, comprehensive statistical analysis was then completed applying weights calculated by SSRC. Additional analysis included collapsing of questions, construction of scale scores and cross-tabulations.

Exhibit 1: Distribution of Completed Surveys and CalOptima Population by Language, Region and Age

Language	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
English	658	11.3%	55.5%
Spanish	715	12.3%	28.6%
Vietnamese	981	16.9%	10.3%
Korean	940	16.2%	1.4%
Farsi	743	12.8%	1.1%
Arabic	648	11.1%	0.6%
Chinese	731	12.6%	0.5%
Other	399	6.9%	2.0%

Region	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
Central	2,315	39.8%	51.5%
North	1,947	33.5%	32.4%
South	1,538	26.4%	15.1%
Out of County	15	0.3%	1.0%

Age	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
0–18 years old	1,665	28.6%	41.8%
19–64 years old	2,453	42.2%	47.2%
65 or older	1,697	29.2%	10.9%

KEY FINDINGS

Given the scope and depth of the study, the MHNA revealed many key findings, which will all be included in the final, comprehensive report. This Executive Summary shares five **key findings**, including related **bright spots** and **opportunities**. Bright spots are CalOptima and community-based resources that already serve to support health behaviors and outcomes. CalOptima can nurture, leverage and build upon these assets. **Opportunities** are areas that CalOptima and its partners can strengthen to positively impact the health and well-being of members.

KEY FINDING: SOCIAL DETERMINANTS OF HEATLH

Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

Given that Medi-Cal eligibility is income-based, it is not surprising that many CalOptima members struggle with economic insecurity. In fact, 55.7 percent of members receive some form of public benefits (Exhibit 2). Further, in the past six months, more than one-quarter of members indicated they needed help with food (32.4 percent), housing (24 percent), money to buy things they need (43.1 percent) and transportation (28.8 percent) (Exhibit 3). Economic stress and financial insecurity cause members and their families to make tradeoffs, such as living in more dense and overcrowded housing with limited space for play and exercise, buying cheaper but less healthy food, or not going to the doctor despite wanting to.

Exhibit 2: Percent of members who receive public benefits (n=5,117)

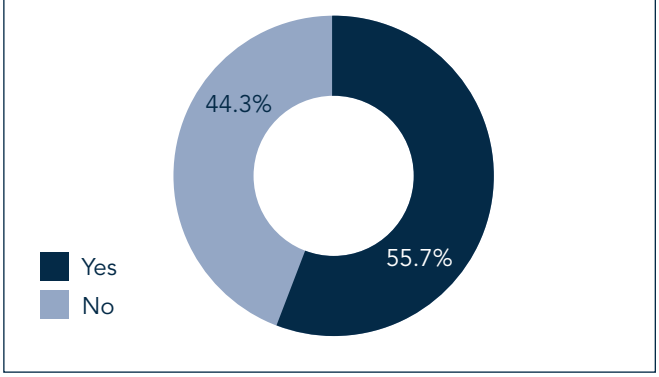
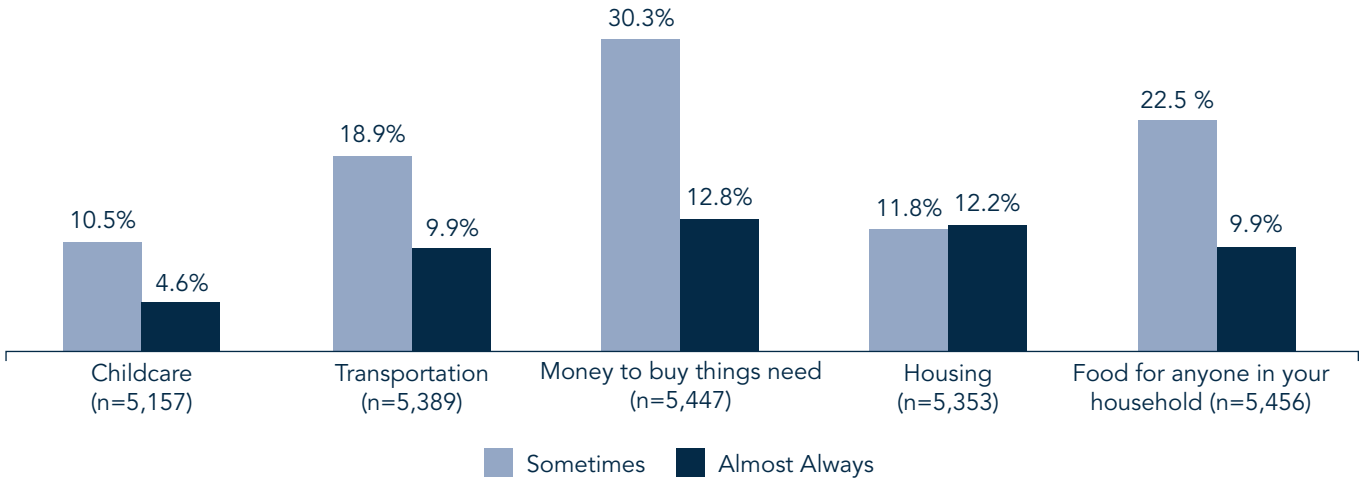
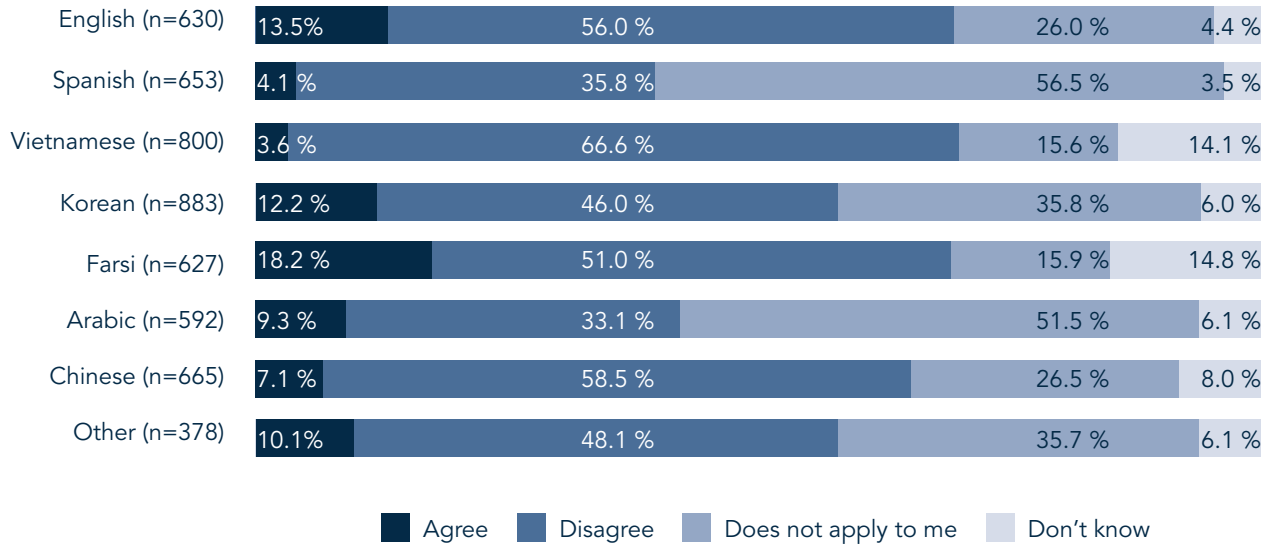


Exhibit 3: Percent of members who needed help with basic needs in the past six months



Social isolation negatively impacts the overall health and well-being of some CalOptima member populations. Social isolation is characterized by a lack of social supports and relationships. It occurs for many reasons, including language barriers, immigration status, age, ability and sexual orientation. In focus groups, members described how feelings of being disconnected from the community can lead to depression, lack of follow-up with health care or service providers, and negative health behaviors. In the survey, 10 percent of all respondents indicated that they felt lonely or isolated. Yet there were higher rates among certain populations, with loneliness and isolation affecting more speakers of English (13.5 percent), Korean (12.2 percent) and Farsi (18.2 percent) (Exhibit 4).

Exhibit 4: Percent of those who reported feeling lonely or isolated by language



Environmental factors also contribute to social isolation and other negative health behaviors, such as lack of physical activity. Focus group participants discussed feeling unsafe in their neighborhoods, which caused them to stay inside or to avoid nearby parks and/or other common spaces.

In addition, lack of affordable housing was a major concern to MHNA respondents, and it resulted in living in overcrowded households, neighborhoods with high crime rates, areas with poor indoor and outdoor air quality, and in the most extreme cases, homelessness.

Bright Spot: CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health a priority, not a lack of knowledge or concern.

Opportunity: CalOptima has already taken steps to strengthen the safety net for members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand this work would positively impact health outcomes in the long run. CalOptima can ensure that providers and community partners understand the social and economic issues that members face and how to adapt health care services accordingly.

KEY FINDING: MENTAL HEALTH

Lack of knowledge and fear of stigma are key barriers to using mental health services.

About 14 percent of members reported needing mental health services in the past year (Exhibit 5). However, local and national data suggest that the need for mental health services is likely underreported and underrecognized. Among those reporting a need, nearly 25 percent did not see a mental health specialist (Exhibit 6). Members did not seek mental health services for several reasons (Exhibit 7), including not knowing who to call or how to ask for help making an appointment (39.8 percent), not feeling comfortable talking about personal problems (37.5 percent) or concern that someone would find out they had a problem (26.1 percent). These factors, along with data gathered from key stakeholder interviews and focus groups, reflect a fear of stigma associated with seeking mental health services.

Exhibit 5: Percent of members who indicated they needed to see a mental health specialist (n=5,723)

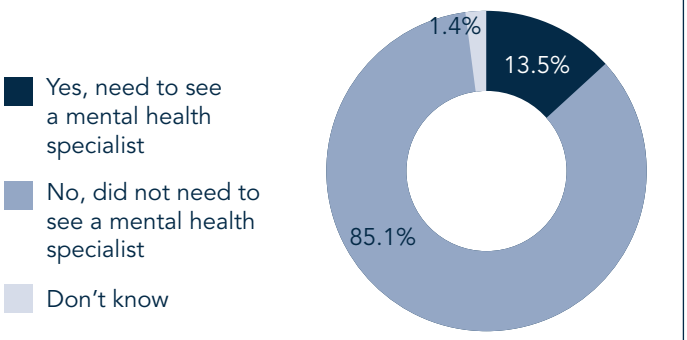
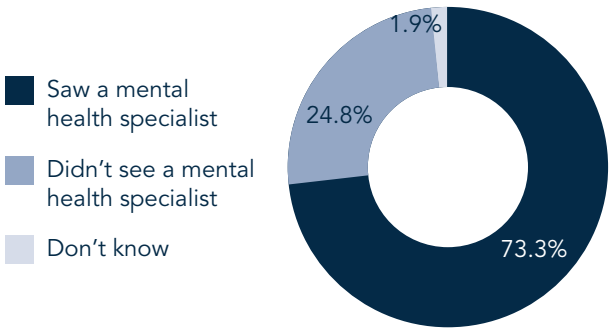
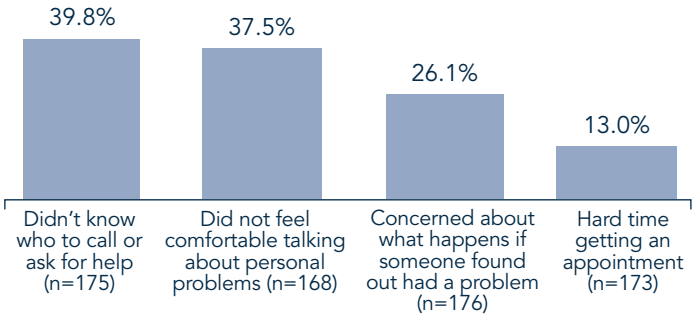


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



Fear of stigma is more prevalent among certain language groups. For example, Chinese-speaking members were more likely to indicate discomfort talking about personal problems and concern about what others might think if they found out about a mental illness than other language groups, followed by Korean-, Vietnamese- and English-speaking members. Conversations with community members and service providers offered cultural context for these findings as many stakeholders described prevalent feelings of shyness, avoidance and shame around discussing mental health issues, let alone seeking care.

Exhibit 7: Reasons why members (who needed to see a mental health specialist but) didn't get services



Bright Spot: CalOptima provides access to mental health services, which meets a clearly established need. Although members needing mental health services do not always connect with providers, many do not do so because of a lack of knowledge, an issue that can be addressed through strengthened connections with existing systems.

Opportunity: Although mental health services are covered by CalOptima, fear of stigma may prevent members from seeking services. This presents an opportunity for CalOptima to continue to provide culturally relevant education around mental health to improve understanding of available services and to address fear of stigma many people face. Community partners with deep knowledge of specific cultural communities are eager to offer support that would increase the use of mental health services.

KEY FINDING: PRIMARY CARE

Most members are connected to primary care, but barriers can make it challenging to receive timely care.

The majority of CalOptima members indicated that they are connected to at least one primary care doctor (82.6 percent), and most go to a doctor's office (69.2 percent) or clinic/health center (18.1 percent) when they need medical attention (Exhibits 8 and 9). However, navigating the health care system can be challenging, and significant barriers make it difficult for people to seek or follow through with care when needed.

Exhibit 8: Percent who report at least one person as their doctor (n=5,749)

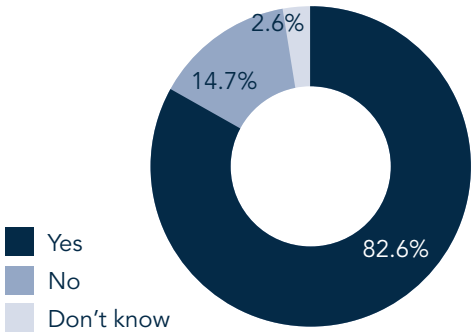
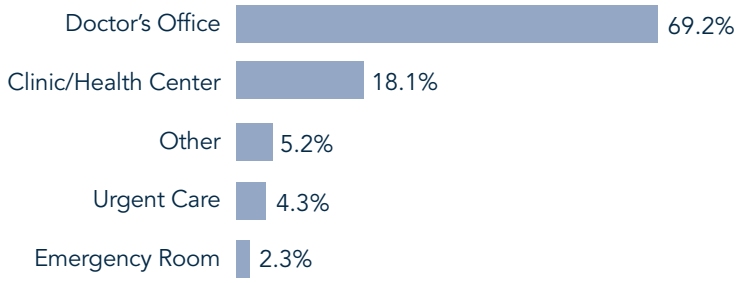


Exhibit 9: Where respondents go to see their doctor (n=5,743)

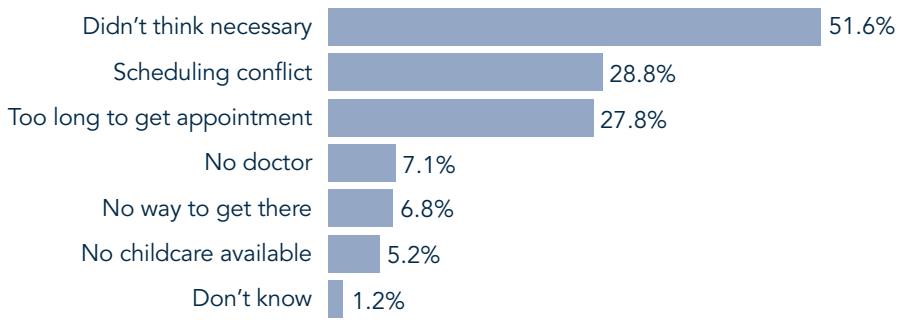


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited hours of operation and inefficiency of public transportation, can make it difficult for people to receive care when needed. When asked why they don't make an appointment to see a doctor, 27.8 percent of CalOptima members indicated that it takes too long to get an appointment while 51.6 percent of members did not think it was necessary to make an appointment (Exhibit 10).

Bright Spot: CalOptima members have access to more than 1,500 primary care providers and 6,200 specialists, as well as 14 different health networks. And staff members are dedicated to continually engaging and educating these providers and networks to ensure they are ready to deliver the care needed by members.

Opportunity: The challenge of maintaining a robust provider network never goes away, and CalOptima must carefully monitor members' access to care. The provider community may be ready to embrace innovations that enhance access, such as extended hours, weekend operations or telemedicine visits, to expand the options for members.

Exhibit 10: Reasons why members don't make an appointment to see doctor (n=4,598)[1]



KEY FINDING: PROVIDER ACCESS

Members are culturally diverse and want providers who both speak their language and understand their culture.

CalOptima members hail from around the globe, reflecting the rich diversity of Orange County's population. In total, 40.3 percent of respondents were born outside of the U.S. and 23.6 percent indicated that they don't speak English well (Exhibits 11 and 12). Among non-English speakers, more than 50 percent were born outside of the United States and many are still acculturating to life in the U.S. This presents challenges when finding a well-paying and fulfilling job, safe and affordable housing, and healthy and familiar food. It also affects the ways members interact with the health care system. In fact, those born outside of the U.S. were significantly less likely to have a doctor and more likely to report feeling lonely or isolated.

Exhibit 11: How well members speak English (n=5,549)

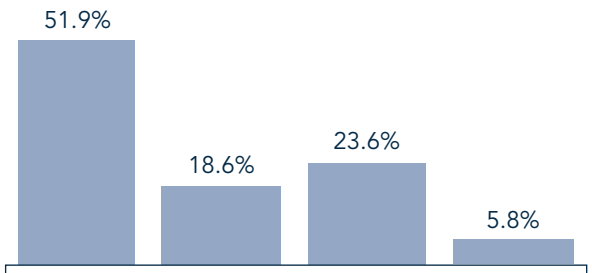
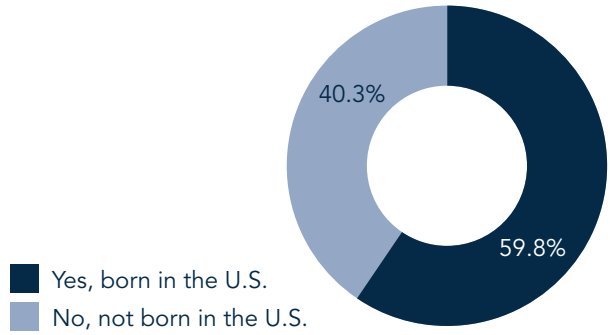


Exhibit 12: Percent of members who were born in the United States (n=5,599)



Further, they report having to adapt to new ways of receiving medical care. Some focus group participants shared that they did not understand why they must wait so long to see a doctor, as it is not this way in their country of origin. Others shared that cultural beliefs and practices made them uncomfortable and often unwilling to see a physician of the opposite gender. In addition, members and key stakeholders indicated that it can be challenging to seek medical care from providers who do not speak members' preferred language, which leads to issues with communication and comfort level. Although many stakeholders highlighted the availability of translation or interpretation services, such services do not always meet members' needs, especially when limited by short appointment times and when sharing sensitive information.

Bright Spot: CalOptima provides services and resources to members in seven languages[2] and can connect members to translation and interpretation services in any language when needed. Members appreciate that CalOptima recognizes the importance of providing care in familiar languages, and they also highly value providers who are sensitive to the cultural norms and practices of their homeland.

Opportunity: CalOptima has an opportunity to build its existing resources and deepen cultural competence of providers and services. CalOptima can engage partners in culturally focused community-based organizations to tailor and implement trainings for providers around specific populations. Trainings can build language and sensitivity skills and increase knowledge in areas such as ethnopharmacology (variations in medication responses in diverse ethnic populations). This can strengthen the workforce and improve member/provider interactions overall.

KEY FINDING: DENTAL CARE

Many members are not accessing dental care and are often unsure about what dental services are covered.

The gap in dental health care is striking and pronounced; 38.2 percent of members indicated they had not seen a dentist within the past 12 months (Exhibit 13). Among those individuals, 41 percent cited cost as the main reason they did not see a dentist (Exhibit 14). Members expressed confusion about dental care benefits available to them via Medi-Cal/Denti-Cal, and they said they would be more likely to seek out a dentist if they knew some of their visits were covered.

Bright Spot: Members in all CalOptima programs are eligible for routine dental care through Denti-Cal, and members in OneCare and OneCare Connect have access to supplemental dental care as well. Better yet, for 2018, California restored additional Denti-Cal benefits, expanding the covered services even further. The challenge is ensuring that members know about these benefits and then actually obtain the services.

Opportunity: To boost the number of members receiving dental care, CalOptima will have to first raise awareness about the availability of services and correct misperceptions that dental care comes at a cost. Further, to remove barriers to care and expand access, the community may embrace the use of alternative providers, such as mobile dental clinics, or the option of co-located dental and medical services.

Exhibit 13: When members last saw a dentist (n=5,685)

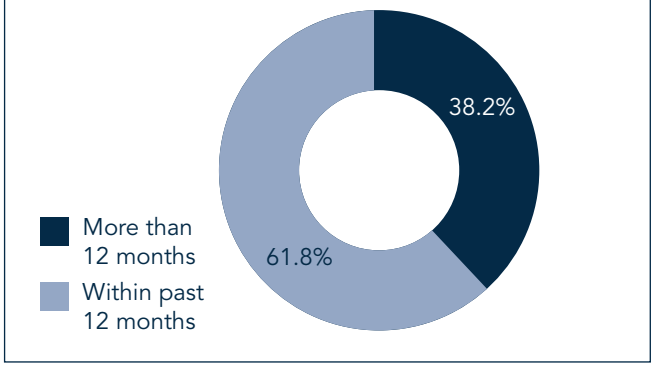
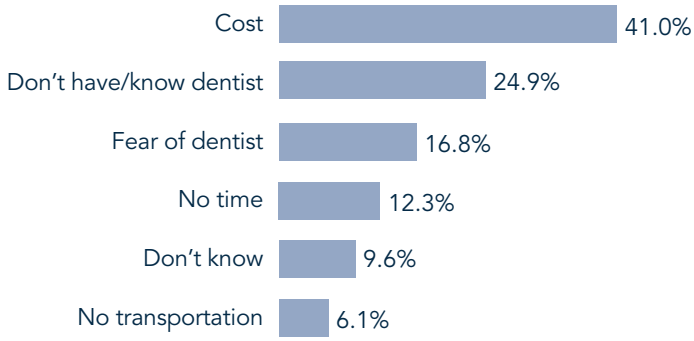


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3][4]



Endnotes

[1] Members could choose multiple answers; thus, the total does not equal 100 percent.

[2] CalOptima provides bilingual staff, interpreter services, health education and enrollment materials in seven languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.

[3] Members could choose multiple answers; thus, the total does not equal 100 percent.

[4] Only reported those who have not seen a dentist within the past 12 months.

January 2018

CalOptima Member Survey Analysis:

Unweighted Estimates by Language, Region, and Age

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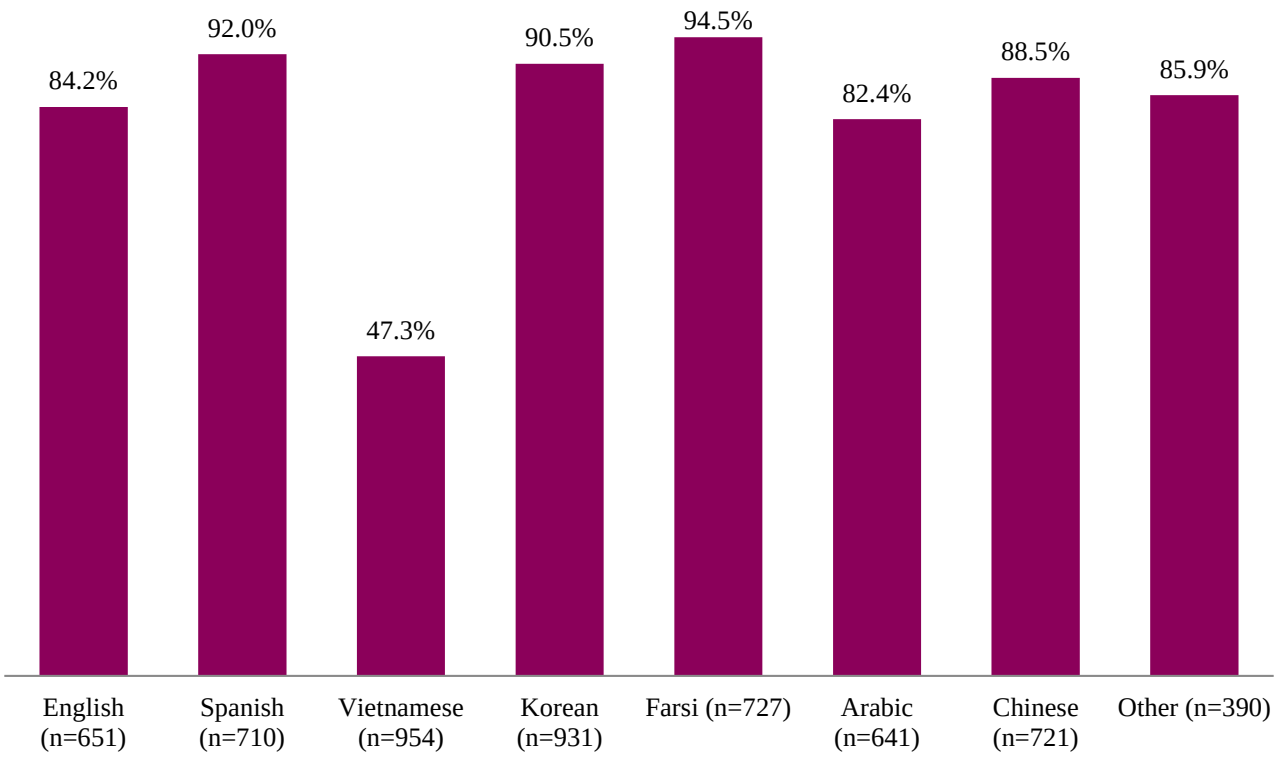
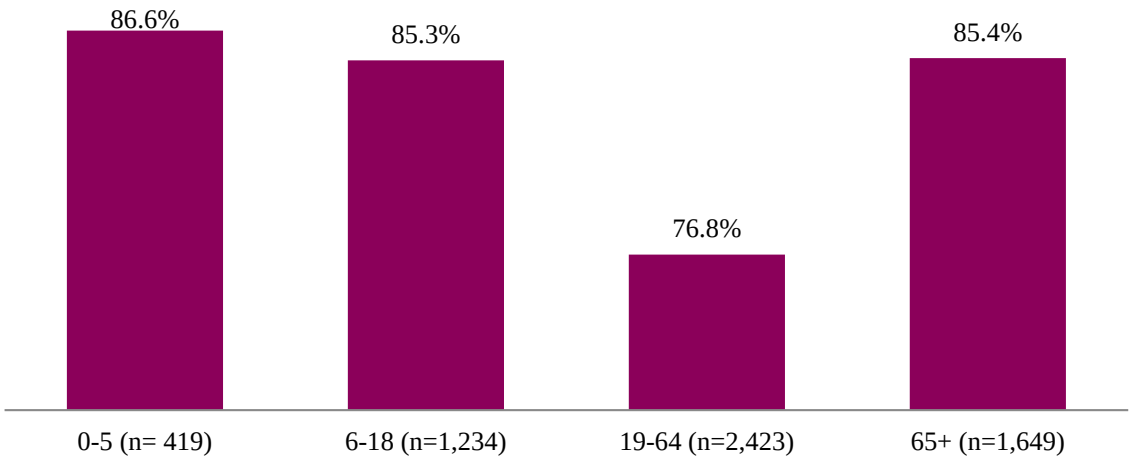
Navigating the Healthcare System

Exhibit 1. Percent who report at least one person as their doctor[1]

CalOptima language:



Age Group:



[1] An issue was identified with the Vietnamese translation of this question. Therefore, results likely misrepresent percentage of Vietnamese members who have a doctor.

Region:

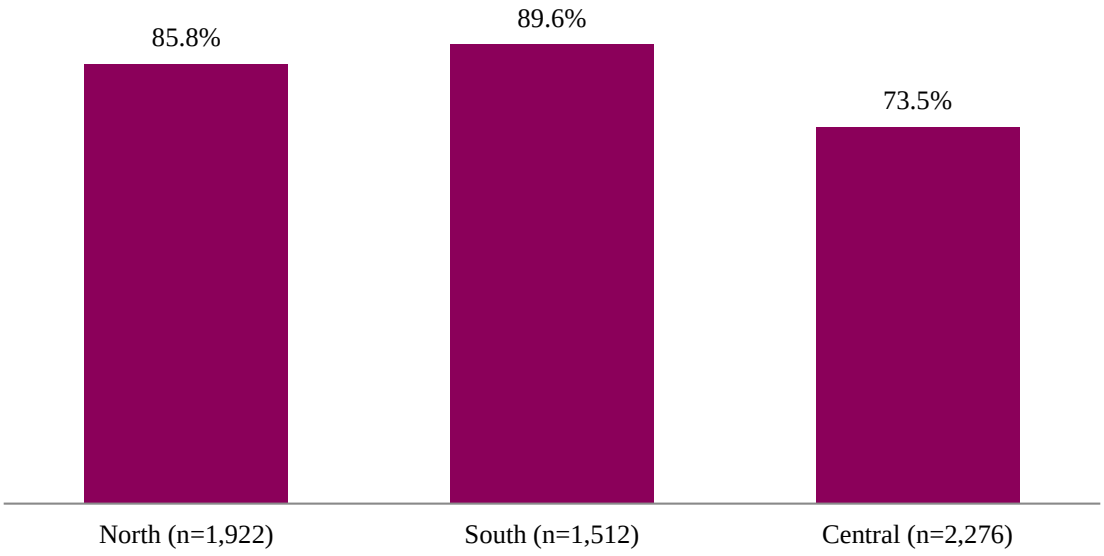


Exhibit 2. Where respondents go to see their doctor

CalOptima language:

CalOptima Language	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
English	71.8%	11.9%	2.0%	6.6%	0.5%	6.4%	0.8%	653
Spanish	59.7%	32.3%	3.4%	1.0%	0.3%	3.1%	0.1%	699
Vietnamese	86.3%	12.0%	0.1%	0.2%	0.0%	1.0%	0.3%	965
Korean	87.8%	4.3%	0.9%	1.1%	0.7%	4.1%	1.2%	938
Farsi	84.0%	6.5%	3.0%	0.8%	0.1%	5.0%	0.5%	737
Arabic	65.3%	15.8%	4.6%	5.4%	0.3%	8.0%	0.5%	625
Chinese	77.2%	11.4%	0.3%	0.8%	0.4%	6.6%	3.3%	727
Other	72.2%	12.6%	1.5%	3.0%	0.0%	9.6%	1.0%	396

Age Category:

CalOptima Age Category	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	68.4%	19.1%	1.9%	2.7%	0.2%	7.2%	0.5%	414
6-18 (Children)	73.0%	16.5%	1.6%	3.0%	0.4%	4.4%	1.0%	1,224
19-64 (Adults/MCE)	73.1%	14.2%	2.6%	2.7%	0.5%	5.5%	1.4%	2,425
65+ (Older Adults)	87.5%	6.8%	0.8%	0.4%	0.1%	4.1%	0.4%	1,677

Region:

CalOptima Region	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
North	74.4%	13.8%	1.7%	3.4%	0.4%	5.4%	1.0%	1,920
South	80.4%	7.9%	2.0%	1.4%	0.5%	6.4%	1.4%	1,521
Central	76.8%	15.5%	1.8%	1.4%	0.2%	3.6%	0.6%	2,284

Exhibit 3. Reasons why members go somewhere other than their doctor when they need medical attention

CalOptima language:

CalOptima Language	I don't have a doctor	It is easier for me to get to the emergency room or urgent care than my doctor's office	It's hard to get an appointment with my doctor	Other	Don't know	n
	%	%	%	%	%	
English	7.4%	26.5%	21.4%	40.7%	4.0%	570
Spanish	7.5%	22.2%	20.1%	37.9%	12.4%	523
Vietnamese	3.1%	31.8%	16.8%	46.2%	2.1%	584
Korean	11.5%	22.7%	27.8%	37.6%	0.4%	687
Farsi	3.1%	15.4%	22.7%	58.8%	0.0%	422
Arabic	5.2%	40.6%	25.5%	28.0%	0.7%	554
Chinese	9.1%	26.8%	14.6%	47.9%	1.6%	549
Other	6.0%	24.9%	16.7%	50.8%	1.6%	317

Age Category:

Age Category	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
0-5 (Children)	4.5%	34.4%	25.4%	29.3%	6.5%	355
6-18 (Children)	5.2%	27.7%	24.0%	36.2%	6.9%	986
19-64 (Adults/MCE)	9.2%	26.0%	23.7%	39.9%	1.3%	1,789
65+ (Older Adults)	4.5%	34.4%	25.4%	29.3%	6.5%	1,076

Region:

Region	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
North	7.4%	27.1%	25.2%	38.4%	1.9%	1,501
South	6.7%	23.1%	20.5%	47.2%	2.5%	1,052
Central	6.3%	28.9%	17.6%	43.2%	4.0%	1,639

Exhibit 4. When do members make an appointment to see doctor[2]

CalOptima Language:

CalOptima Language	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
English	75.8%	77.2%	51.8%	1.1%	4.2%	650
Spanish	77.7%	76.2%	36.9%	0.8%	4.5%	713
Vietnamese	76.0%	74.7%	39.7%	0.1%	1.7%	973
Korean	81.3%	75.2%	47.4%	0.4%	0.6%	938
Farsi	87.4%	80.0%	65.1%	1.8%	3.7%	736
Arabic	82.5%	40.4%	30.9%	0.5%	1.4%	644
Chinese	80.3%	73.6%	48.6%	1.5%	1.2%	727
Other	70.1%	82.0%	51.1%	1.5%	4.6%	395

Age Category:

Age Category	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
0-5 (Children)	86.4%	76.9%	41.9%	0.7%	1.2%	420
6-18 (Children)	81.8%	73.2%	39.9%	0.5%	2.2%	1,236
19-64 (Adults/MCE)	78.0%	67.9%	47.3%	1.1%	2.3%	2,433
65+ (Older Adults)	77.8%	77.4%	50.0%	0.9%	3.4%	1,687

[2] **Members were allowed to choose multiple answers; thus, the total does not equal 100%.**

Region:

Region	When Sick	Check-Up	Specialist Needed	Don't Know	Other	n
	%	%	%	%	%	
North	78.2%	70.5%	43.6%	0.9%	2.3%	1,938
South	83.3%	75.9%	55.9%	1.3%	2.8%	1,527
Central	77.7%	72.0%	41.8%	0.5%	2.5%	2,296

Exhibit 5. Reasons why members don't make an appointment to see doctor[3]

CalOptima language:

CalOptima Language	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
English	7.8%	6.7%	28.0%	27.6%	5.2%	54.0%	1.8%	554
Spanish	6.3%	6.5%	20.8%	27.4%	5.2%	53.2%	0.8%	504
Vietnamese	2.3.%	7.0%	50.9%	24.8%	4.1%	42.8%	0.0%	725
Korean	11.7%	4.1%	48.4%	39.7%	3.8%	31.5%	0.0%	677
Farsi	5.7%	19.5%	24.9%	45.1%	6.9%	33.3%	0.0%	406
Arabic	2.7%	7.0%	28.2%	42.6%	2.1%	37.1%	0.0%	561
Chinese	7.2%	9.6%	29.8%	24.8%	2.2%	51.0%	0.9%	541
Other	4.1%	8.8%	25.0%	29.1%	1.7%	56.8%	0.0%	296

[3] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Age Category:

Age Category	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	4.6%	6.5%	32.8%	35.9%	10.5%	43.7%	0.0%	323
6-18 (Children)	4.8%	4.5%	38.2%	32.8%	3.9%	43.4%	0.1%	990
19-64 (Adults /MCE)	7.8%	7.4%	36.3%	34.5%	4.2%	39.5%	0.8%	1,933
65+ (Older Adults)	4.5%	13.3%	26.1%	26.9%	1.3%	53.2%	0.3%	1,018

Region:

Region	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%			
North	7.6%	7.7%	36.3%	35.0%	3.3%	40.5%	0.3%	1,521
South	6.3%	10.5%	27.5%	35.8%	4.8%	45.7%	0.6%	1,019
Central	4.6%	6.9%	35.9%	28.1%	4.0%	46.1%	0.5%	1,712

Exhibit 6. When do members make an appointment to see a specialist[4]

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
English	76.0%	26.5%	63.5%	638
Spanish	71.9%	30.5%	60.7%	679
Vietnamese	70.3%	24.4%	56.7%	949
Korean	69.1%	27.1%	45.2%	877
Farsi	78.6%	31.4%	55.7%	688
Arabic	68.9%	16.3%	42.5%	631
Chinese	66.0%	35.6%	45.4%	694
Other	79.2%	26.8%	59.9%	384

Age Category:

Age Category	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
0-5 (Children)	71.1%	28.4%	53.8%	394
6-18 (Children)	67.7%	25.7%	52.6%	1,172
19-64 (Adults/MCE)	71.5%	25.2%	54.5%	2,328
65+ (Older Adults)	75.7%	31.3%	51.7%	1,646

[4] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

Region:

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
North	69.3%	27.7%	50.6%	1,857
South	74.3%	28.3%	52.9%	1,453
Central	72.6%	26.6%	55.5%	2,216

Exhibit 7. Reasons why members don't make an appointment to see specialist[5]

CalOptima Language:

CalOptima Language	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
English	19.5%	8.0%	20.4%	27.0%	41.1%	548
Spanish	7.9%	5.5%	12.0%	20.2%	46.4%	560
Vietnamese	11.3%	9.3%	37.8%	30.7%	33.4%	724
Korean	14.2%	12.5%	32.6%	41.5%	27.6%	696
Farsi	13.9%	14.3%	15.2%	37.6%	24.5%	474
Arabic	9.9%	6.9%	21.5%	47.1%	25.6%	577
Chinese	11.9%	14.6%	17.6%	25.4%	42.6%	556
Other	15.6%	12.6%	16.5%	27.2%	39.2%	334

Age Category:

Age Category	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
0-5 (Children)	10.8%	8.1%	22.8%	33.5%	41.0%	334
6-18 (Children)	12.1%	7.9%	27.2%	32.1%	35.9%	1,019
19-64 (Adults/MCE)	13.7%	9.8%	24.9%	35.5%	31.6%	1,953
65+ (Older Adults)	12.6%	13.8%	16.3%	27.6%	37.0%	1,163

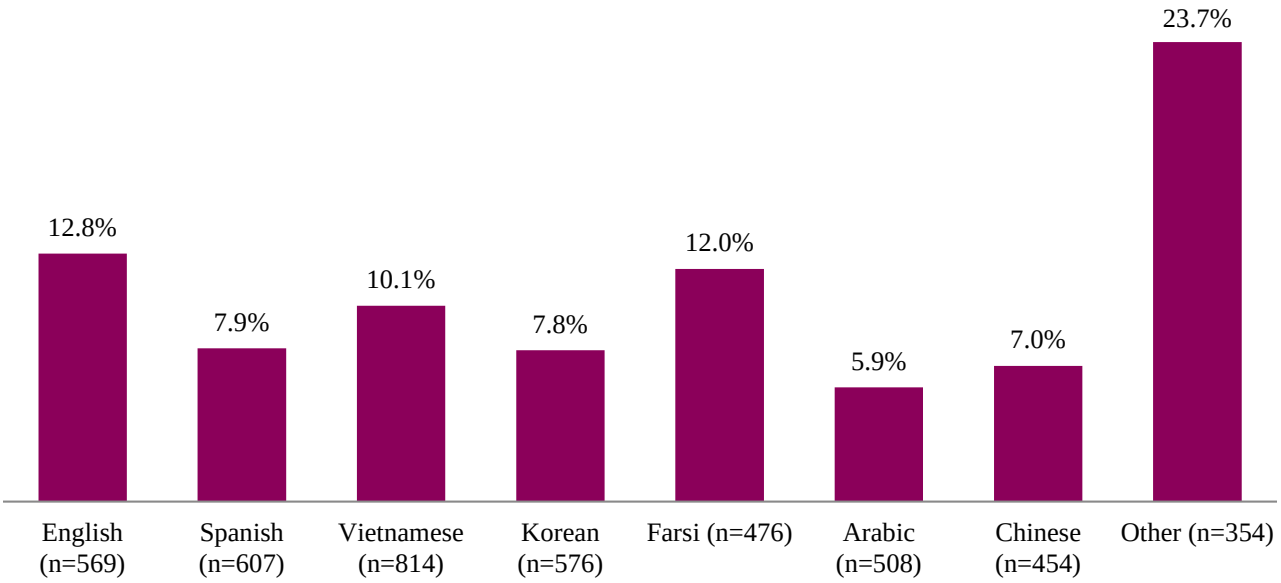
[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Region:

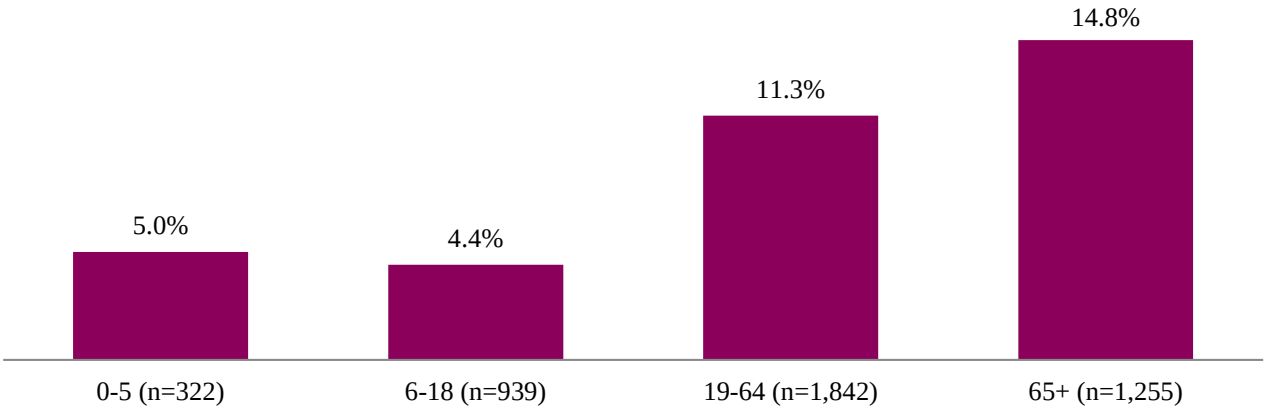
Region	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
North	14.0%	11.3%	24.8%	35.9%	31.1%	1,567
South	13..6%	11.3%	17.5%	33.6%	35.9%	1,097
Central	11.4%	8.8%	24.9%	28.9%	37.2%	1,792

Exhibit 8. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor

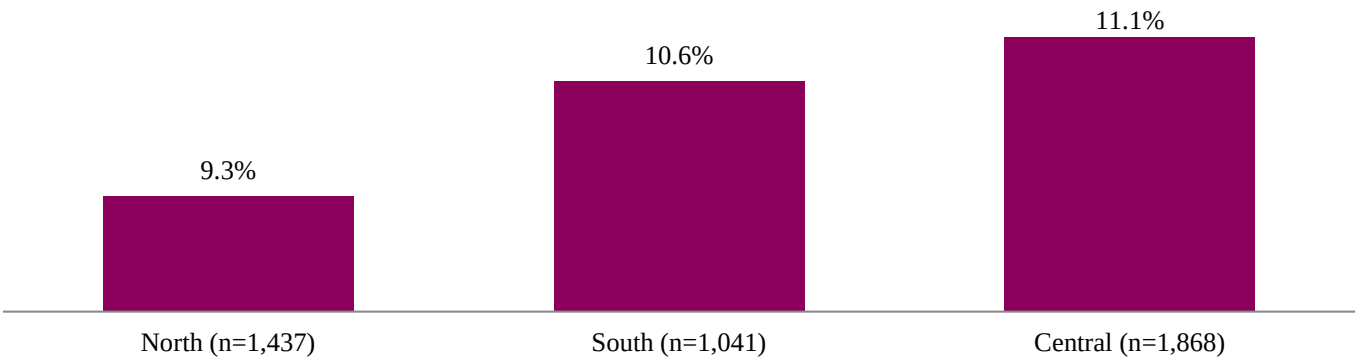
CalOptima language:



Age Category:



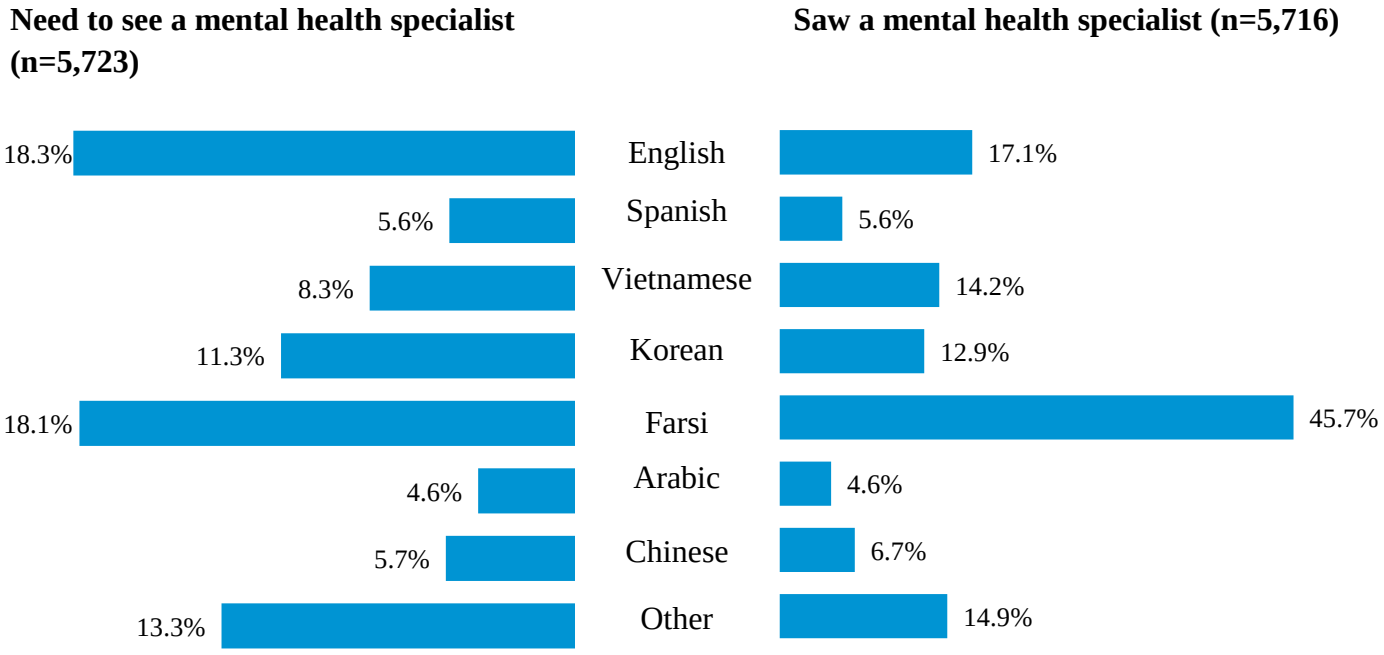
Region:



Social and Emotional Well-Being

Exhibit 9. Members who needed to see compared to those who saw a mental health specialist in the last 12 months[6]

CalOptima Language:

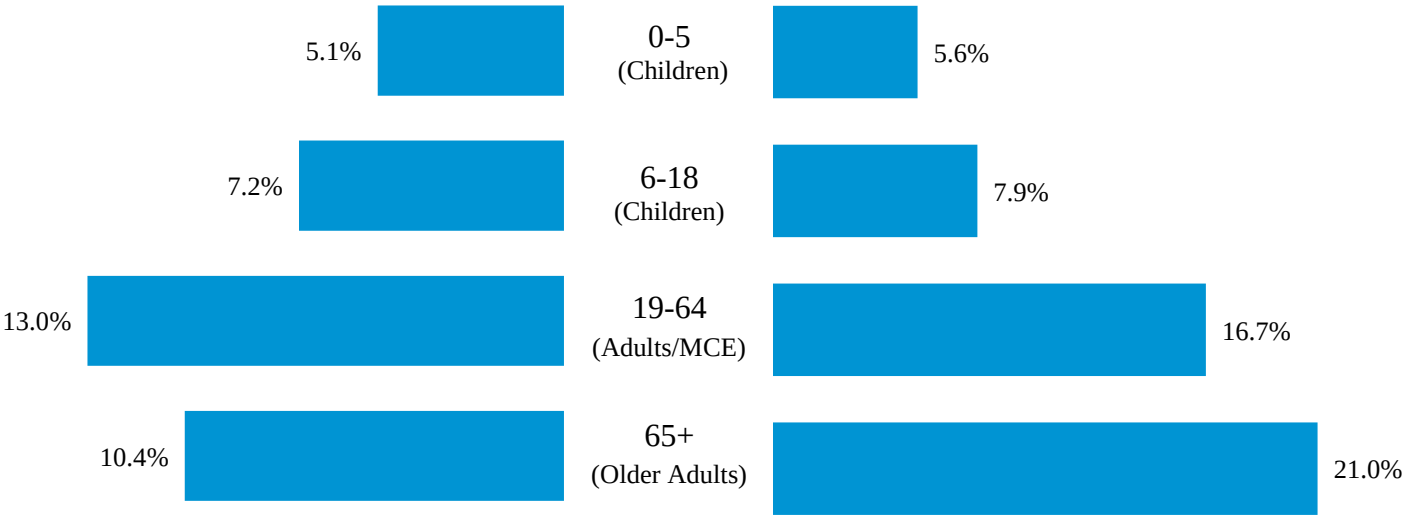


[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

Age Category:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)



Region:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)

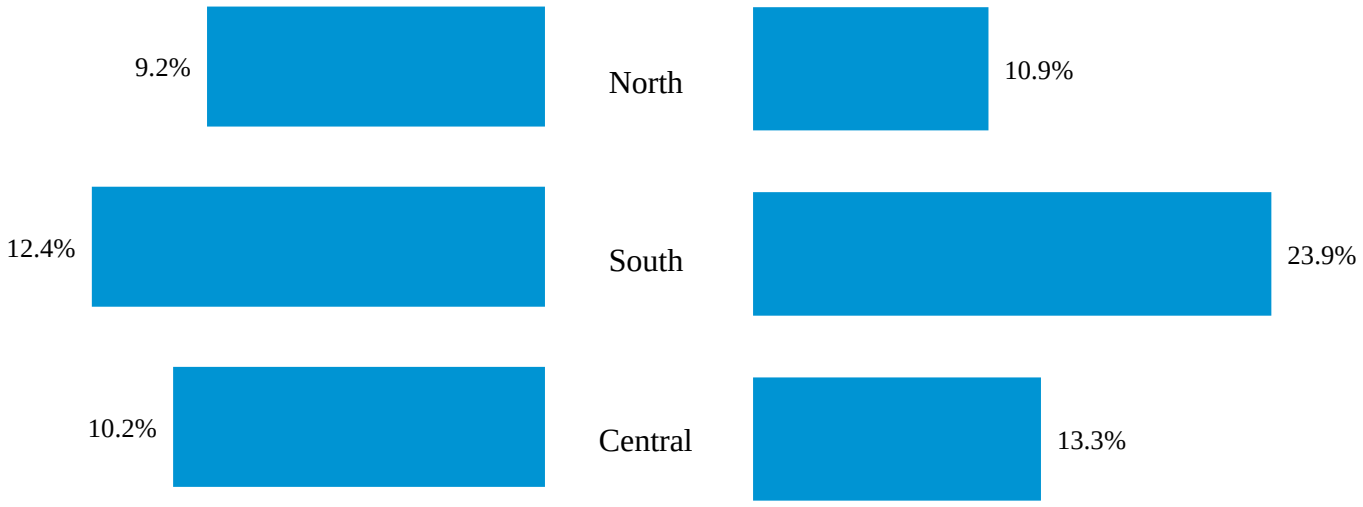
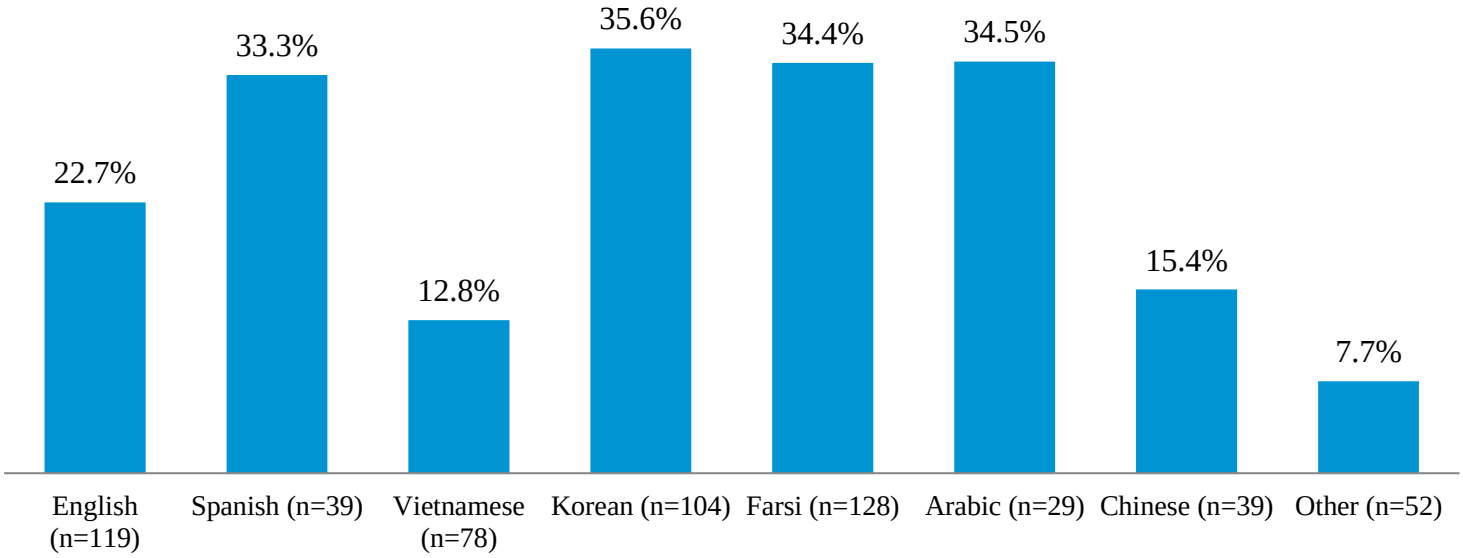
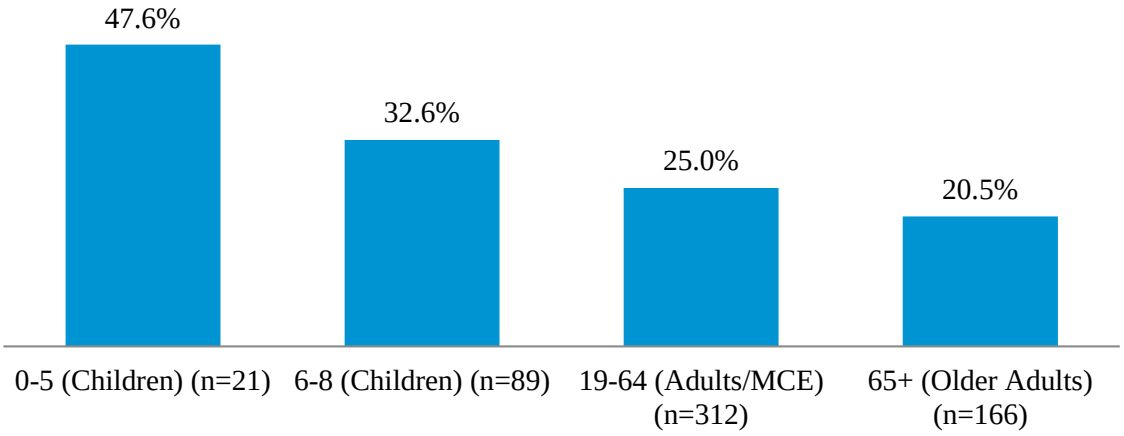


Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist

CalOptima Language:



Age Category:



Region:

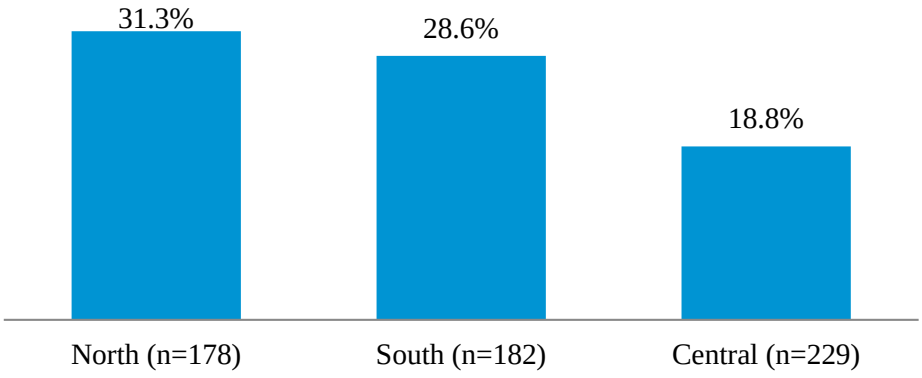
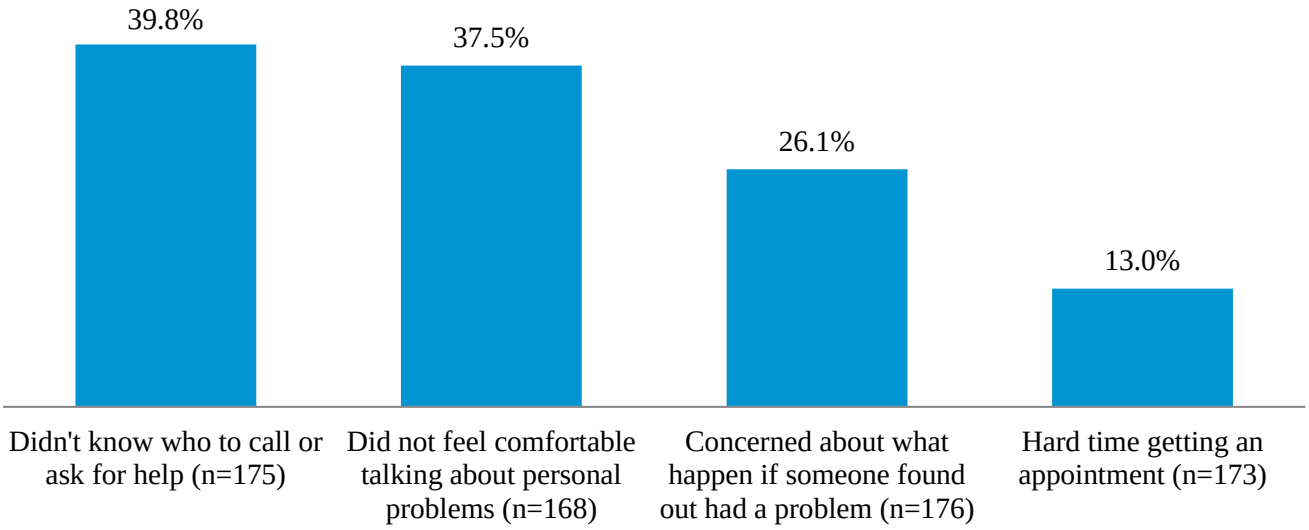


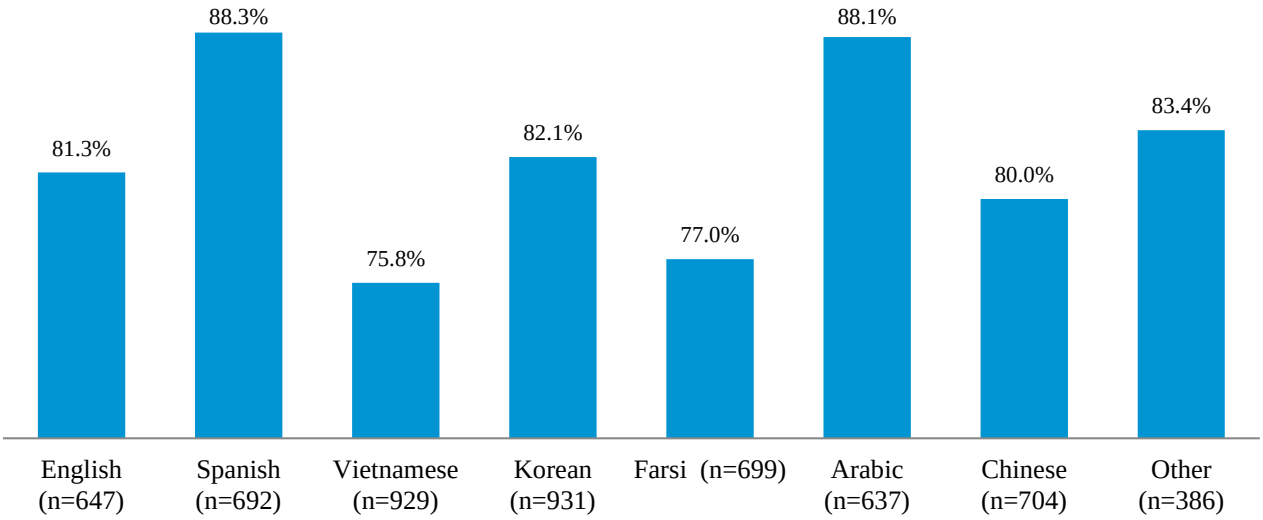
Exhibit 11. Reasons why members didn't see mental health specialist[7]



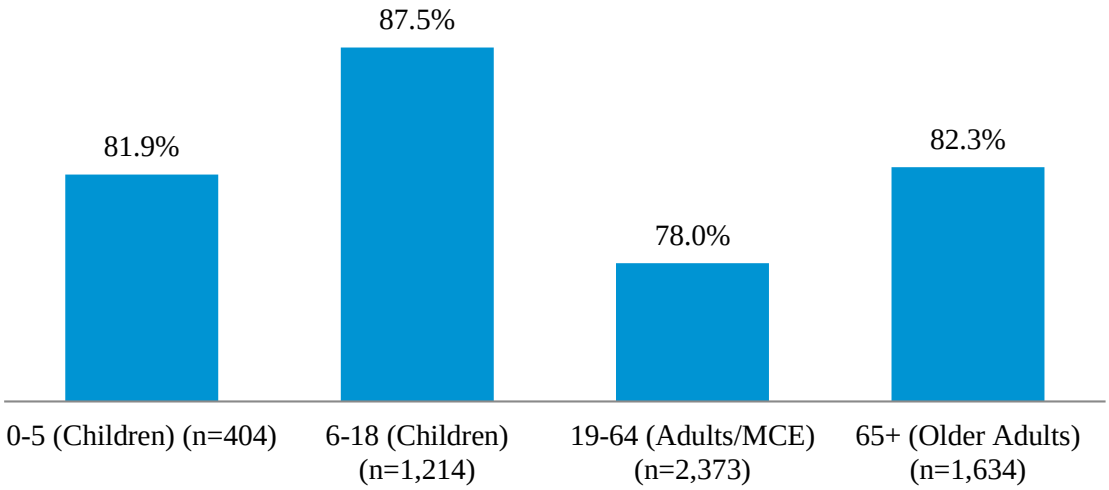
[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

Exhibit 12. Percent of members who can share their worries with family members

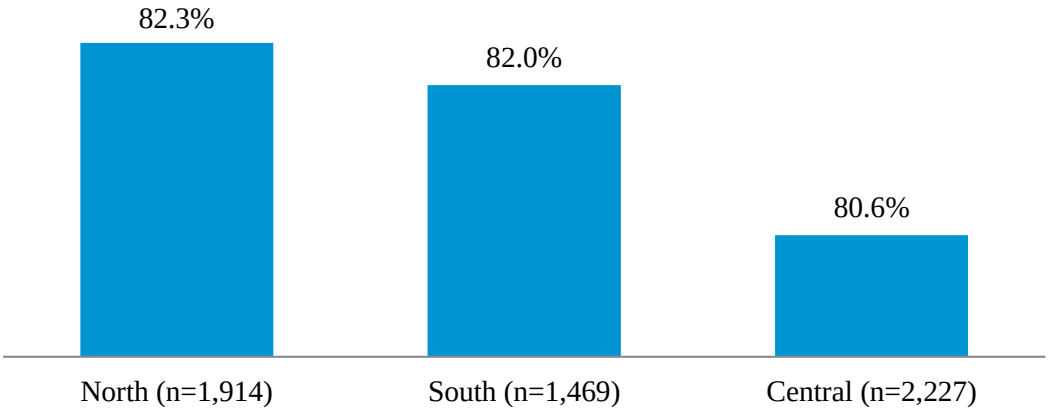
CalOptima language:



Age Category:



Region:

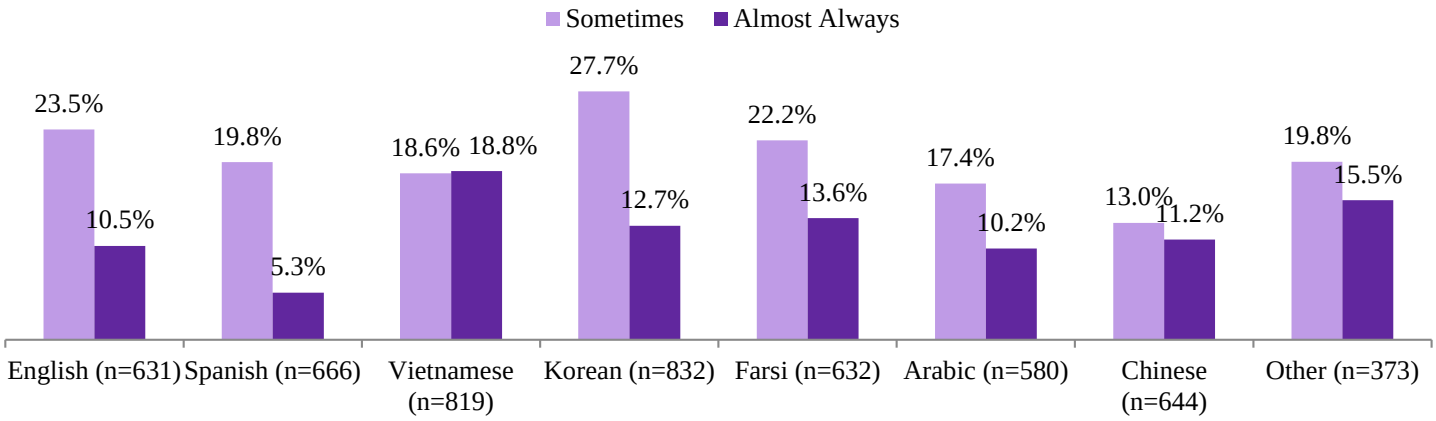


Social Determinants of Health

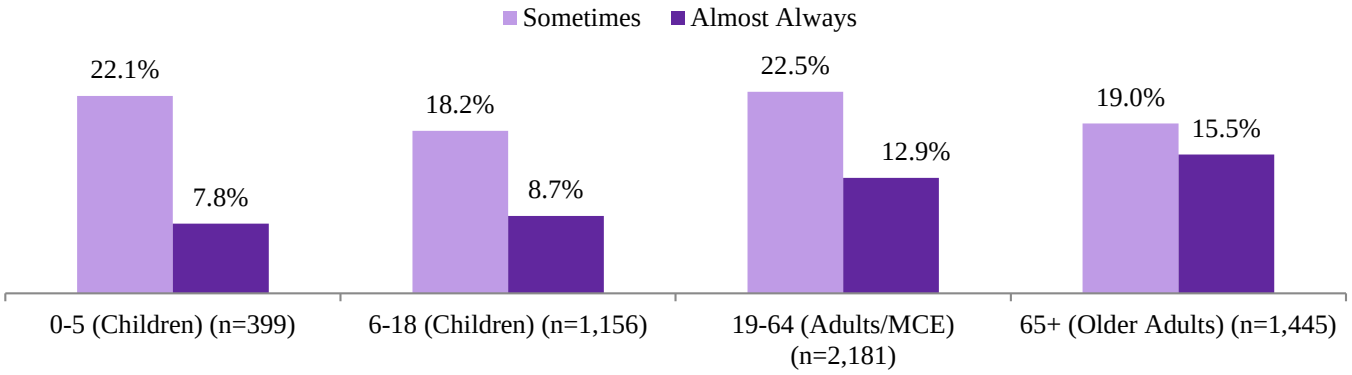
Exhibit 13. Needed help with the following in the past 6 months:

Food for anyone in your household:

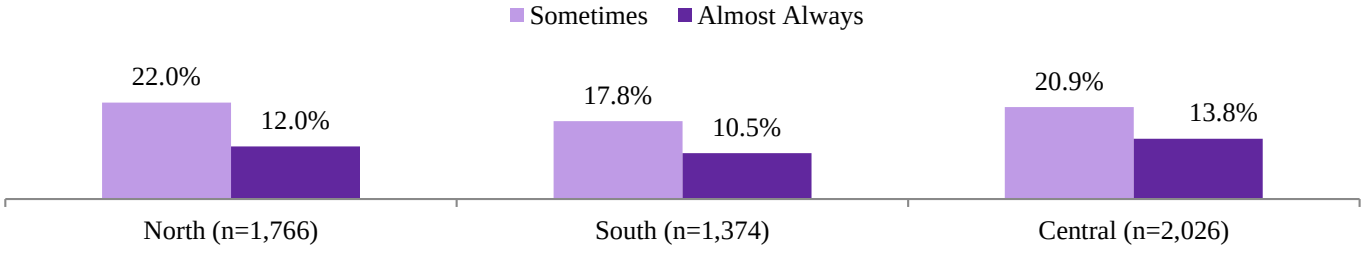
CalOptima language:



Age Category:

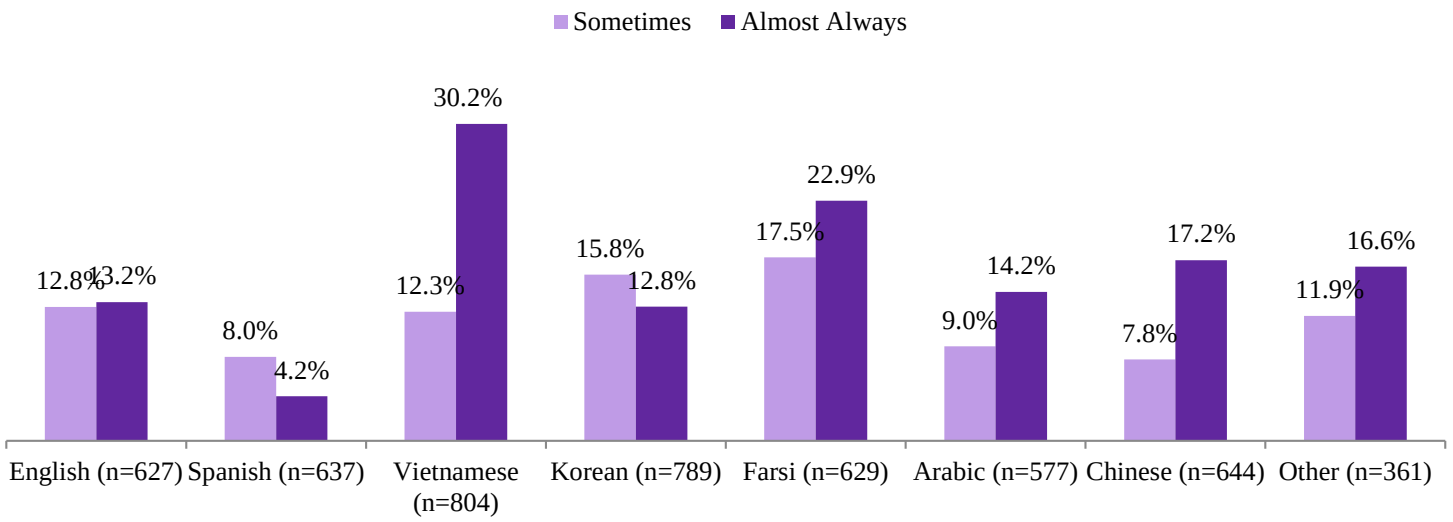


Region:

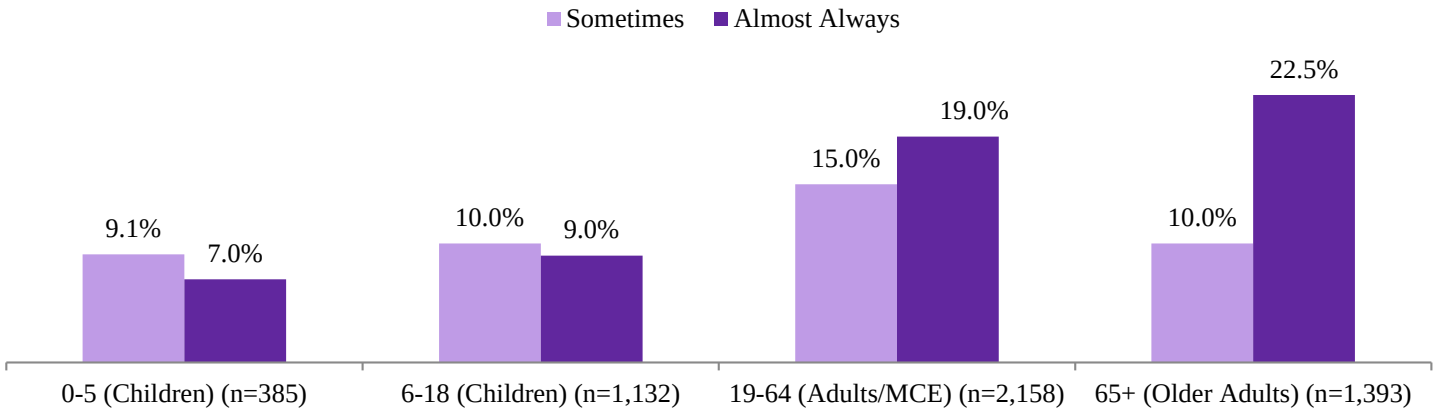


Housing:

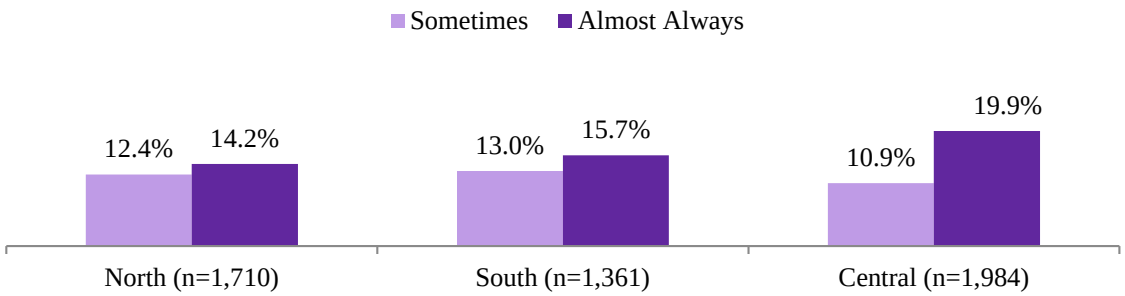
CalOptima language:



Age Category:

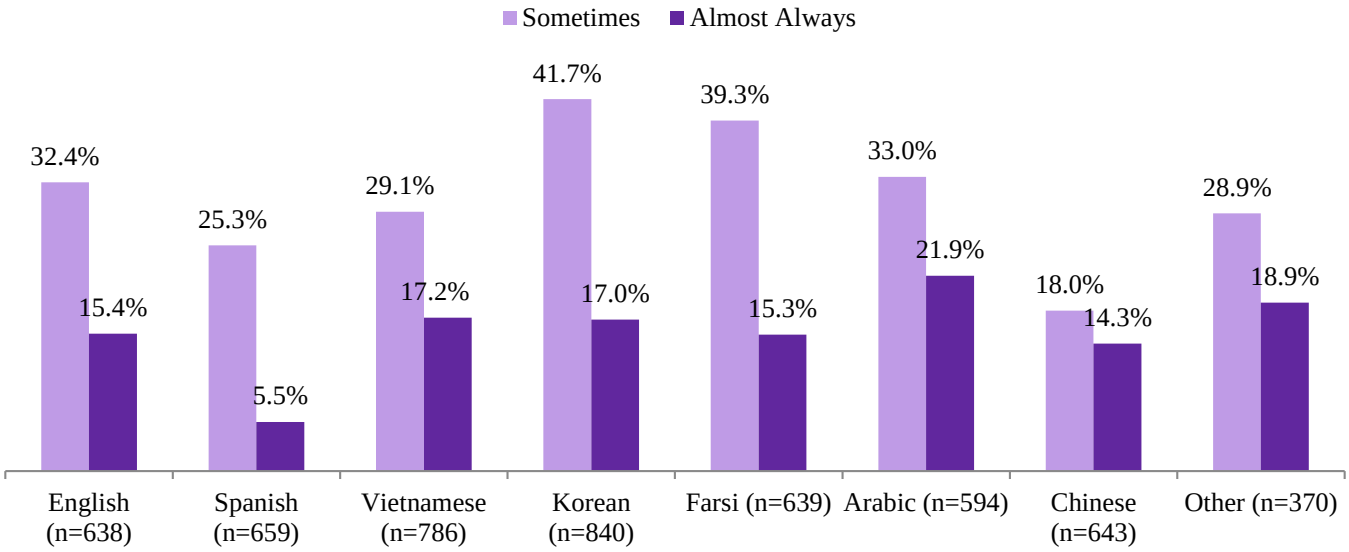


Region:

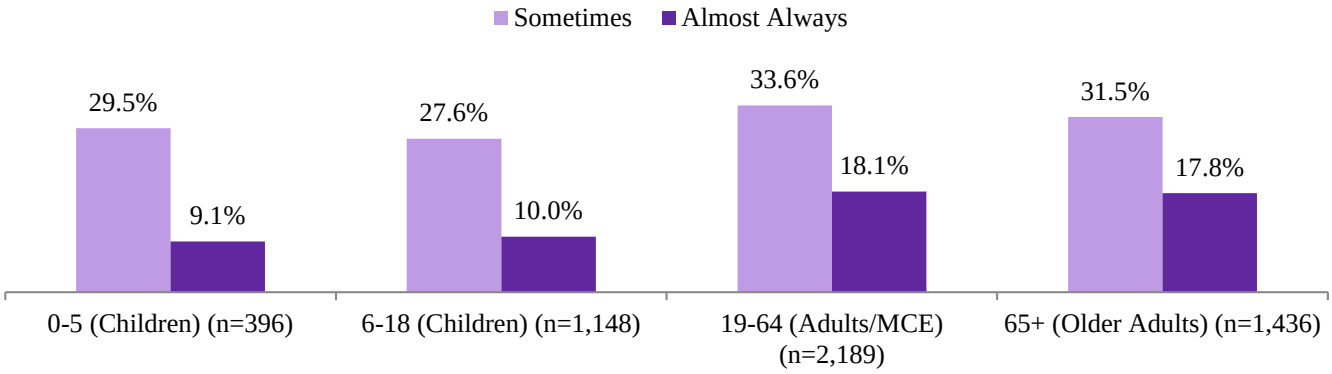


Money to buy things need:

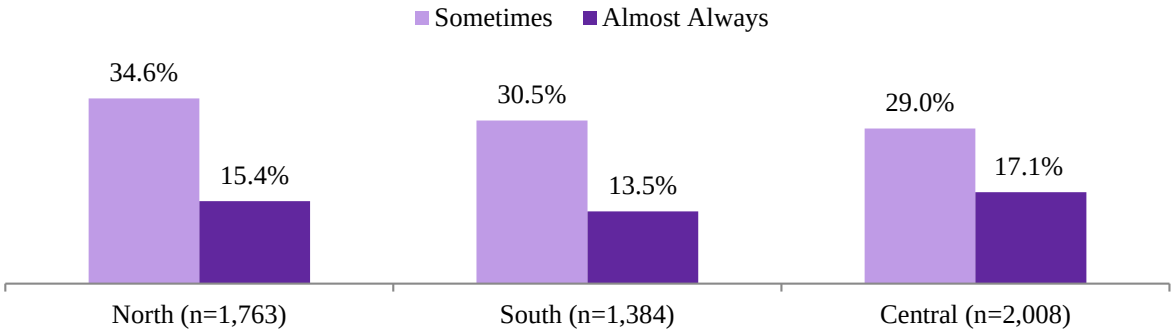
CalOptima language:



Age Category:

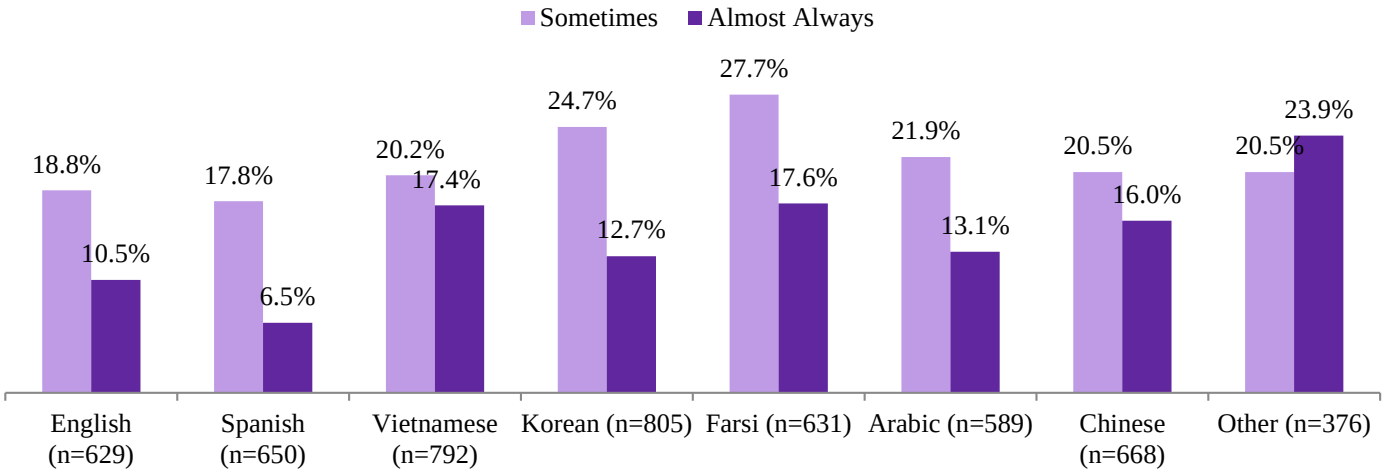


Region:

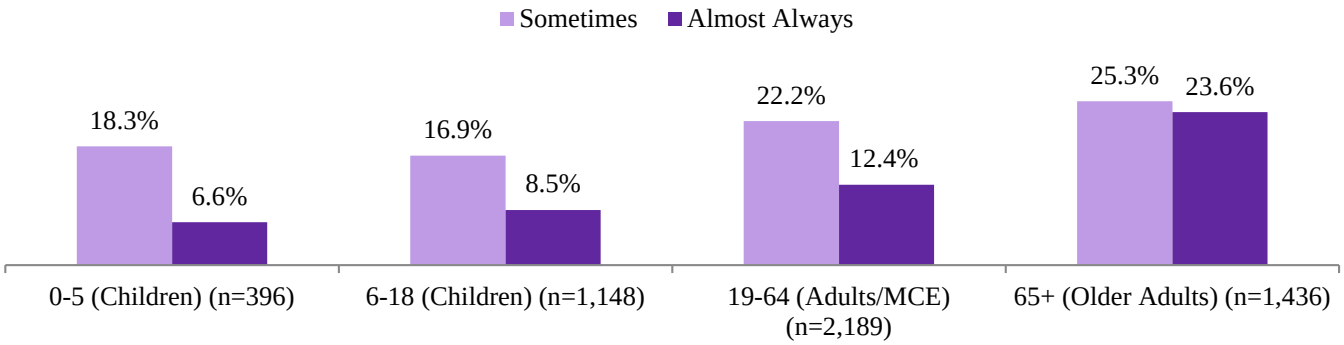


Transportation:

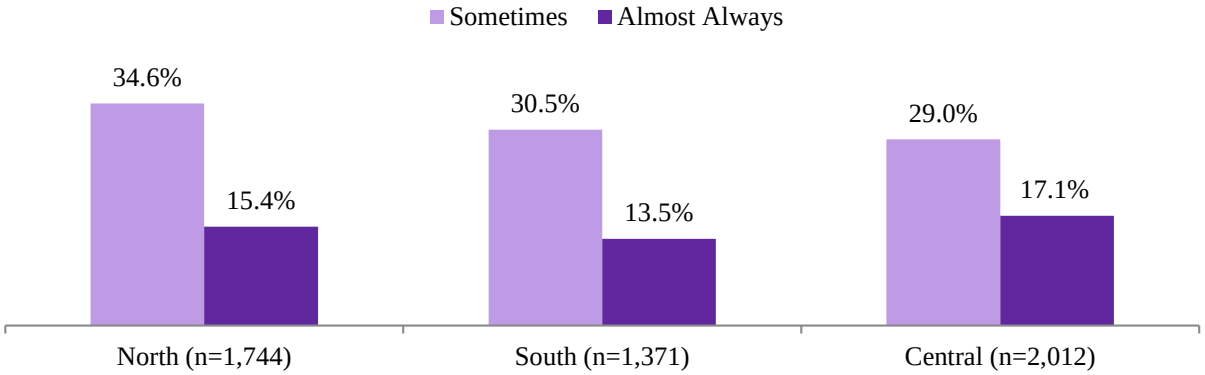
CalOptima language:



Age Category:

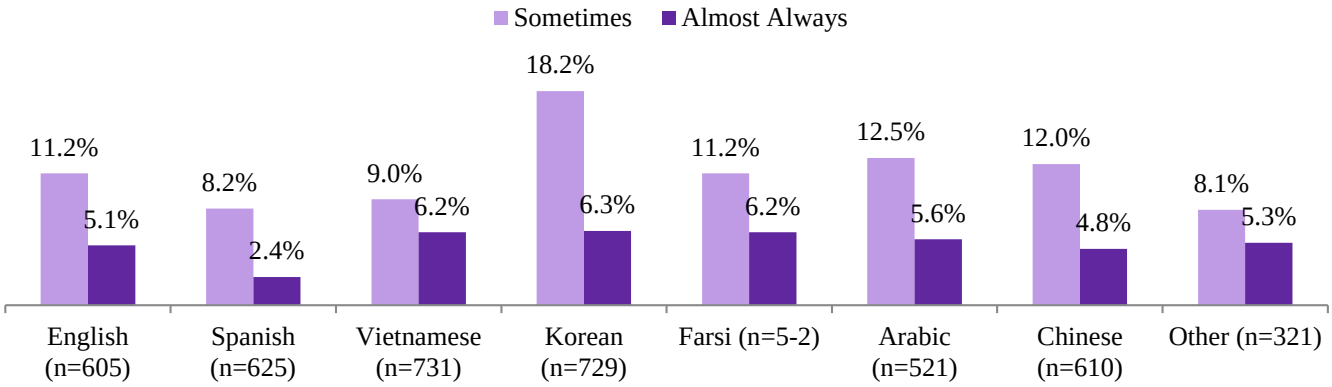


Region:

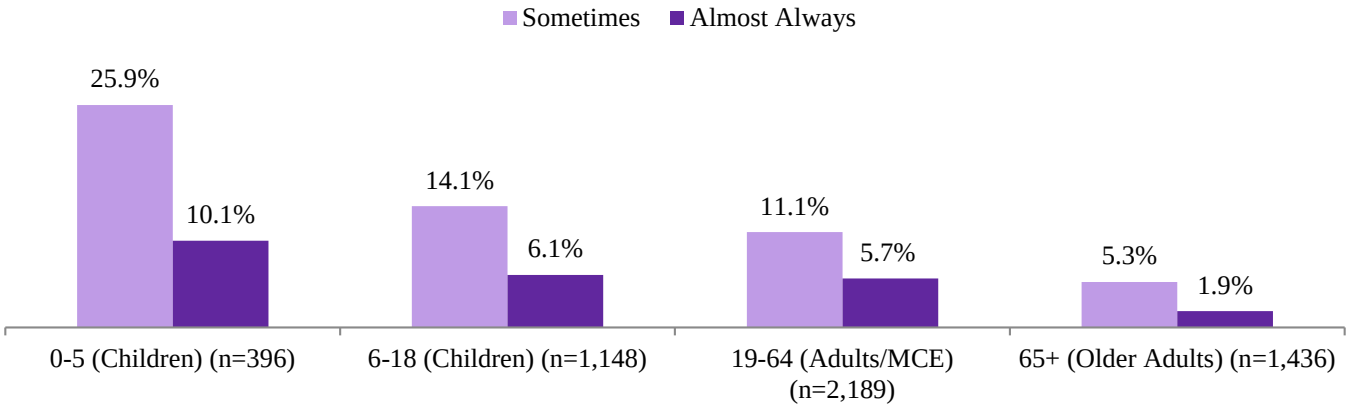


Child care:

CalOptima language:



Age Category:



Region:

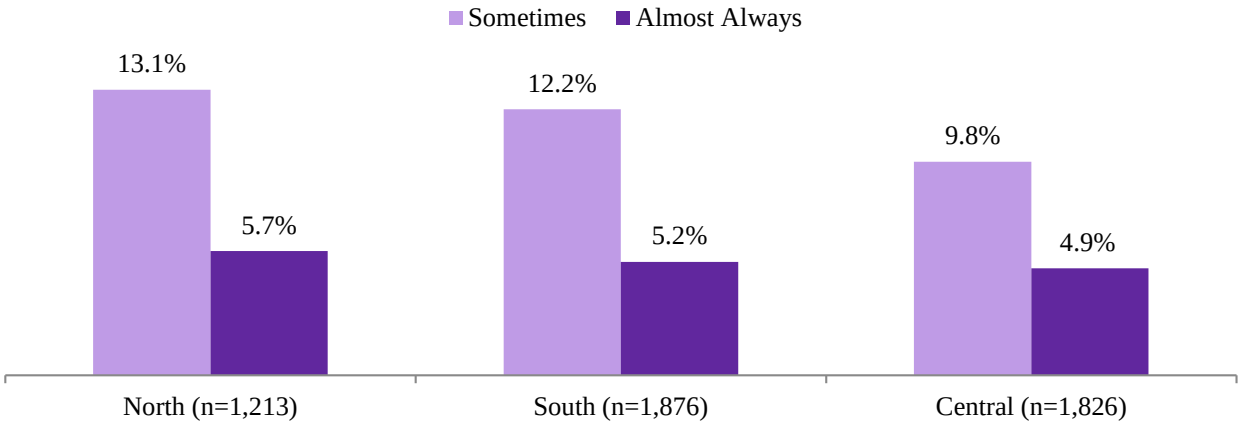
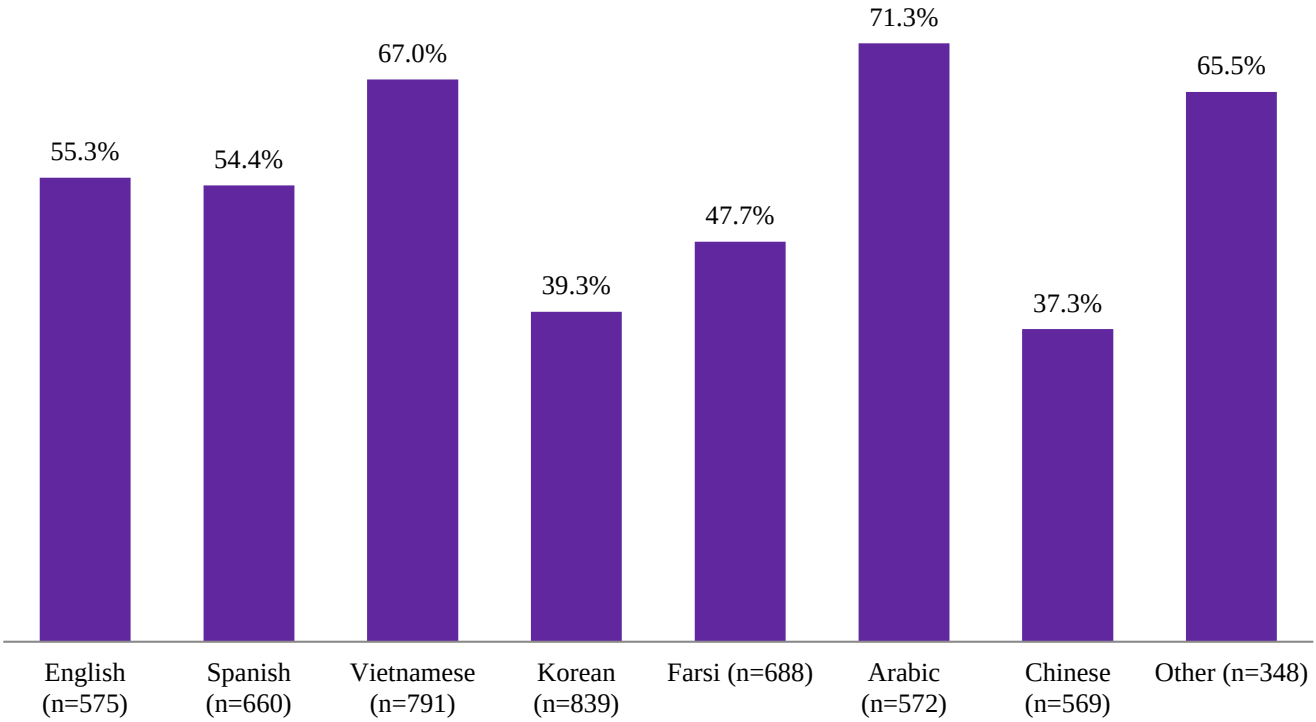


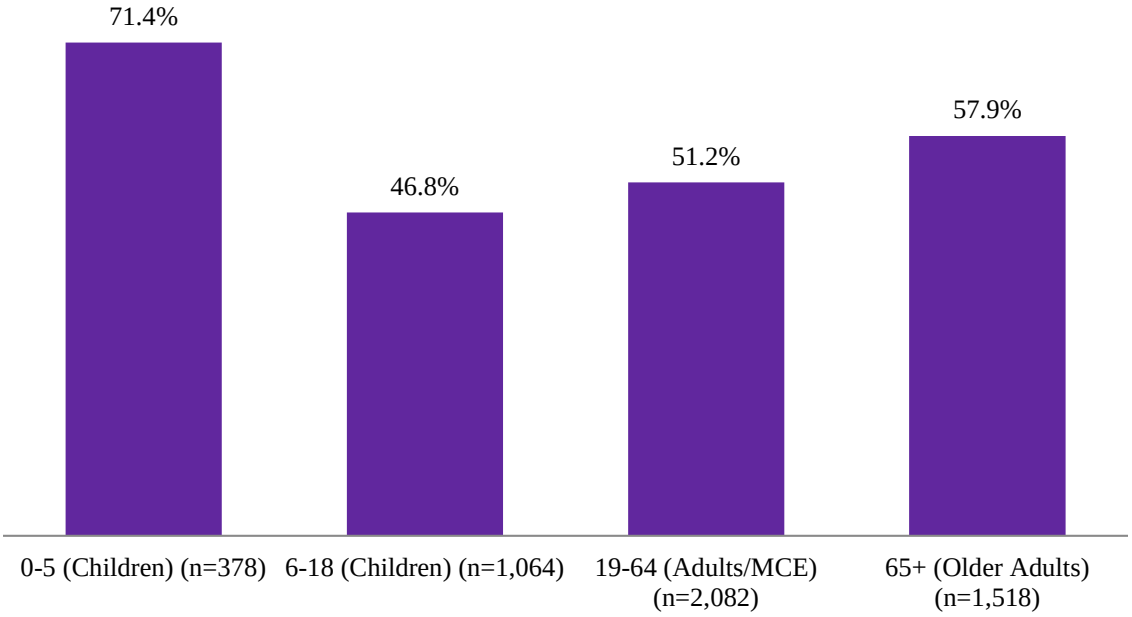
Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

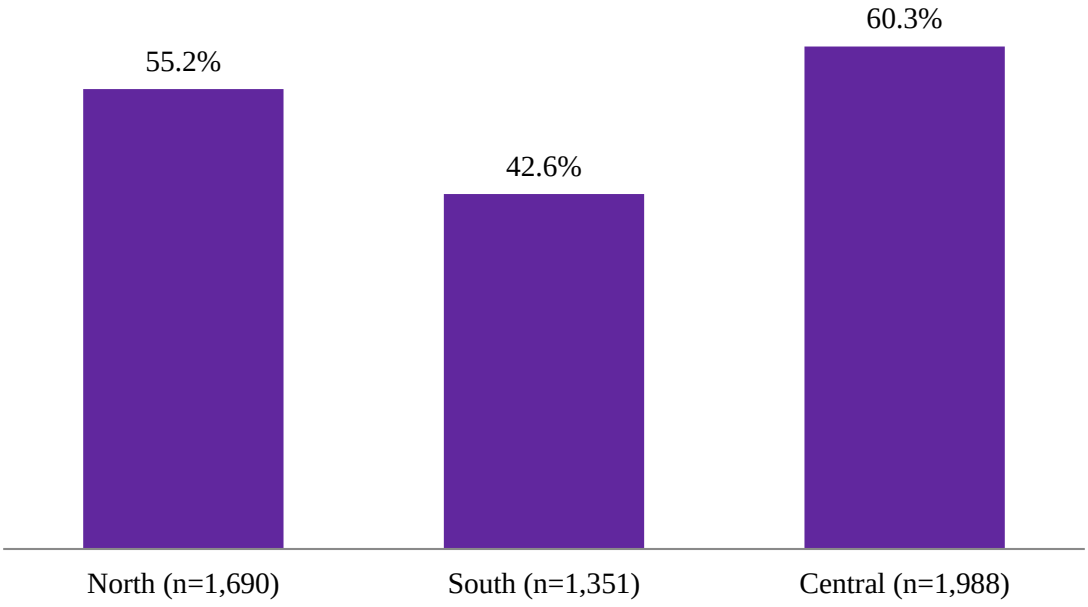
CalOptima language:



Age Category:



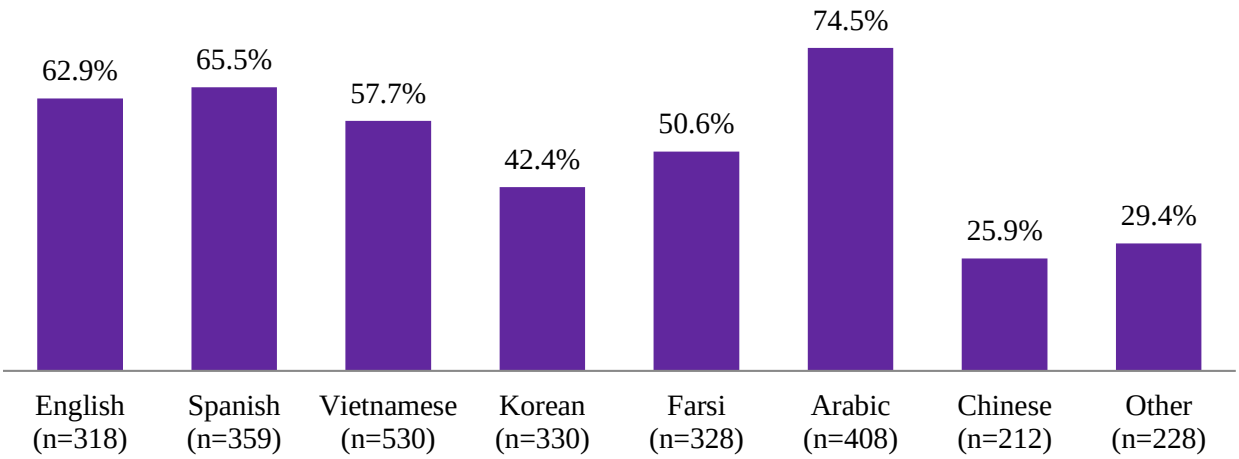
Region:



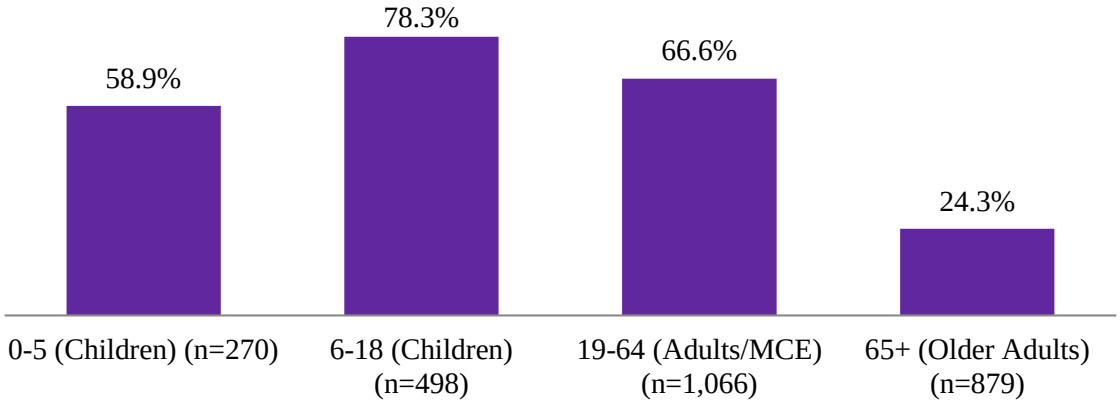
Type of public benefits that members receive[8]:

Receive CalFresh as a public benefit:

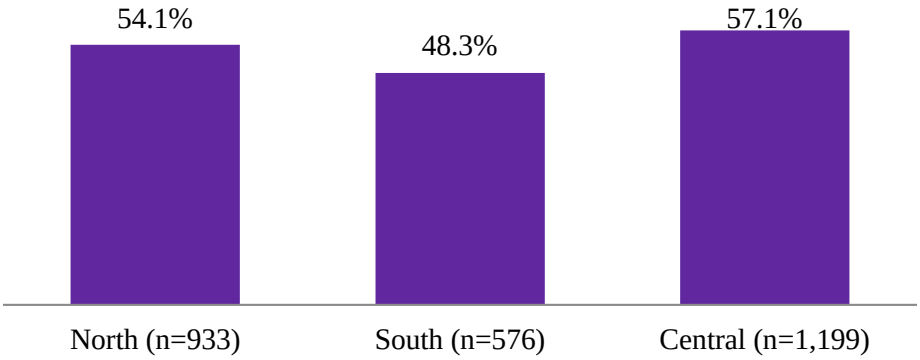
CalOptima language:



Age Category:



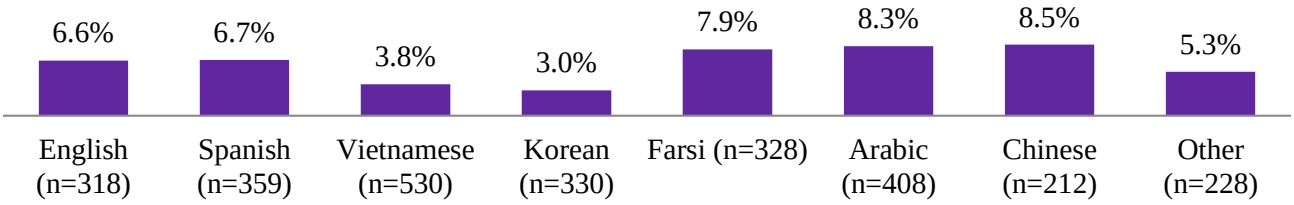
Region:



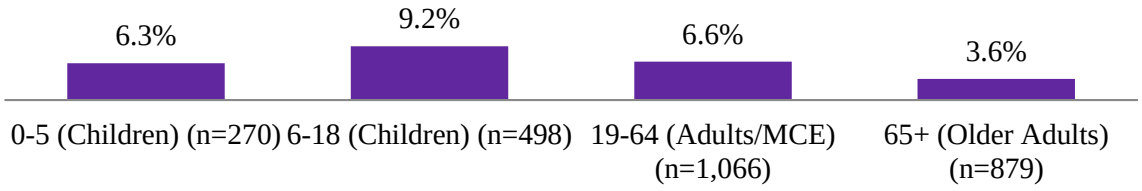
[8] Only reporting those who reported that they received at least one public benefit.

Receive TANF or CalWorks as a public benefit:

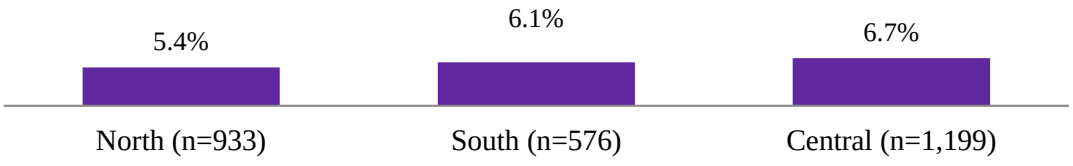
CalOptima language:



Age Category:

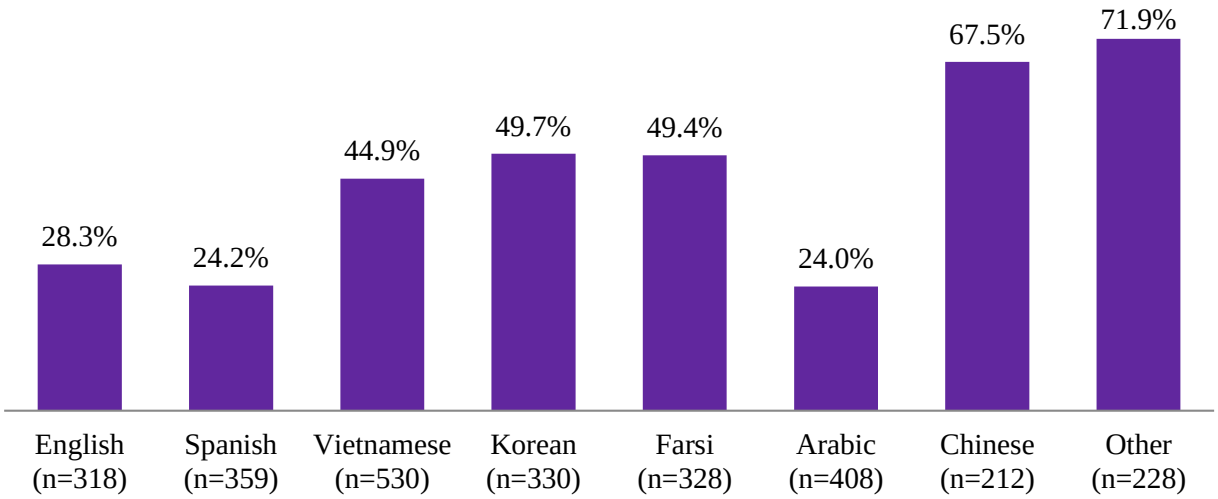


Region:

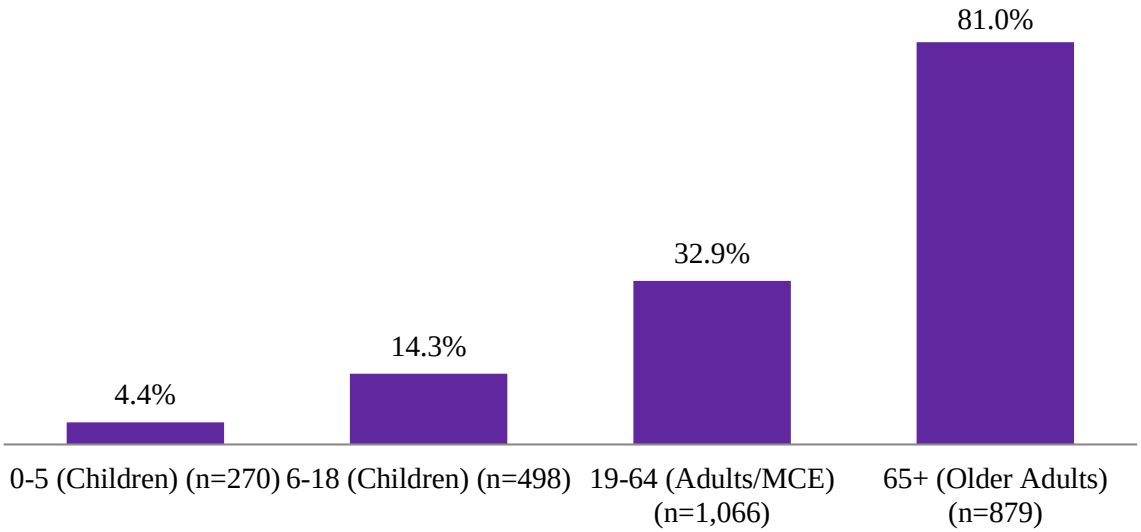


Receive SSI or SSDI as a public benefit:

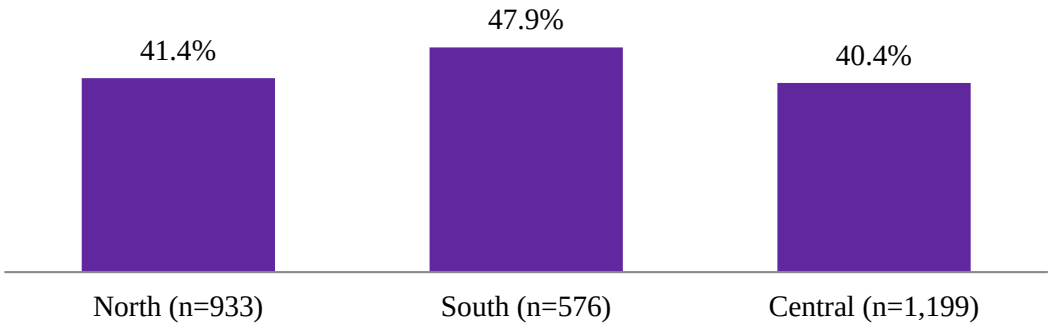
CalOptima language:



Age Category:

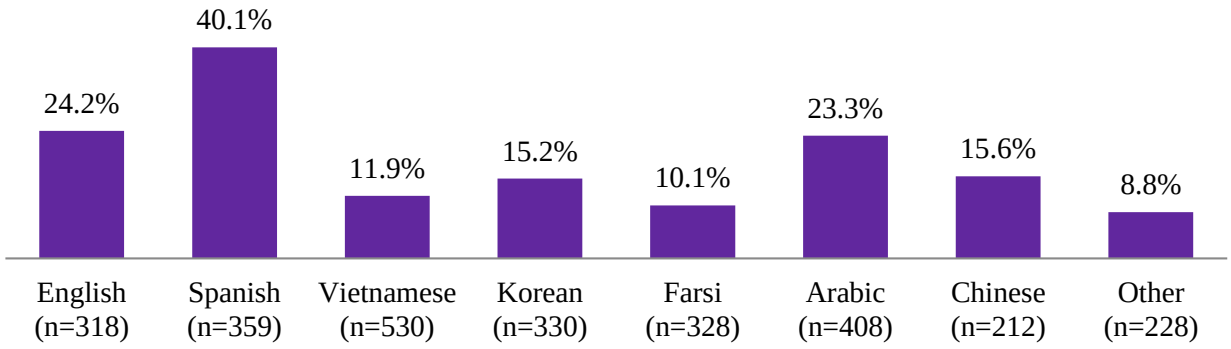


Region:

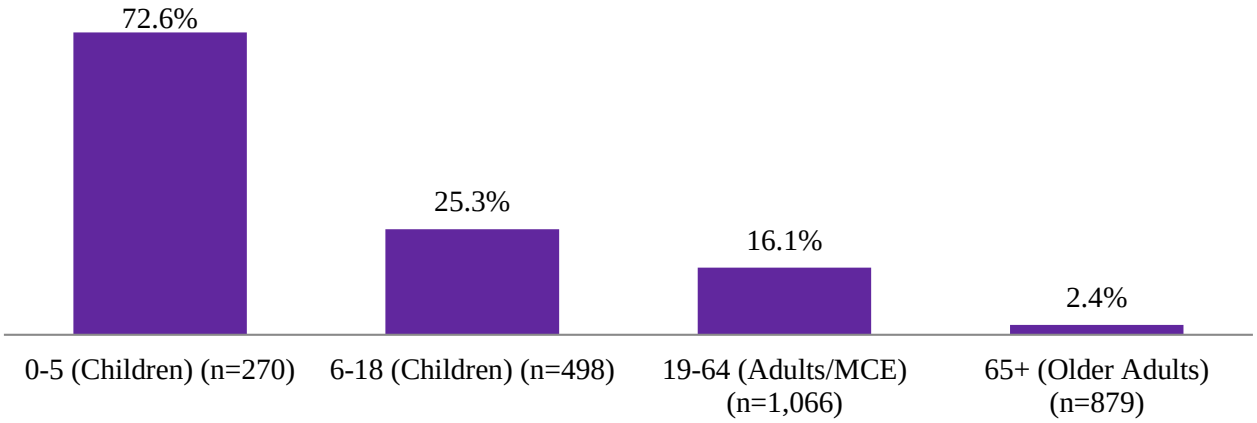


Receive WIC as a public benefit:

CalOptima language:



Age Category:



Region:

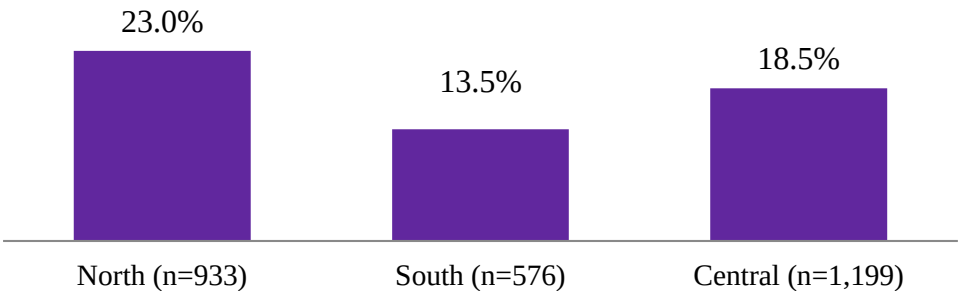


Exhibit 15. Personal activities participation:

CalOptima language:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	41.2%	6.4%	6.4%	45.9%	621
Spanish	19.1%	4.3%	3.1%	73.5%	607
Vietnamese	53.5%	3.3%	4.3%	38.9%	766
Korean	35.4%	6.3%	2.3%	56.0%	809
Farsi	28.5%	3.2%	3.4%	65.0%	537
Arabic	47.2%	5.9%	1.9%	45.0%	540
Chinese	16.8%	3.8%	3.1%	76.3%	583
Other	32.3%	4.0%	5.1%	58.6%	350
Do fun activities with others	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
English	63.3%	18.3%	7.4%	11.0%	635
Spanish	61.8%	13.0%	4.0%	21.2%	647
Vietnamese	49.6%	19.5%	9.3%	21.7%	789
Korean	51.9%	22.7%	7.3%	18.0%	859
Farsi	39.5%	25.0%	10.2%	**25.3%**	608
Arabic	54.8%	20.6%	6.7%	17.9%	586
Chinese	45.4%	12.1%	5.8%	**36.7%**	619
Other	46.3%	21.6%	11.6%	20.5%	361

Volunteer or charity	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	16.2%	15.8%	19.4%	48.6%	628
Spanish	15.9%	10.0%	9.9%	64.2%	628
Vietnamese	15.8%	19.1%	26.7%	38.3%	752
Korean	21.0%	13.2%	15.6%	50.2%	825
Farsi	15.4%	13.8%	19.9%	50.9%	578
Arabic	23.5%	18.1%	14.3%	44.2%	575
Chinese	16.5%	11.9%	14.0%	57.7%	607
Other	9.9%	7.0%	12.1%	71.0%	355

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	68.7%	11.5%	6.0%	13.7%	633
Spanish	66.0%	8.7%	2.8%	22.5%	644
Vietnamese	69.6%	6.6%	4.0%	19.8%	807
Korean	75.1%	10.1%	3.7%	11.2%	874
Farsi	68.9%	7.7%	5.6%	17.9%	627
Arabic	59.1%	11.8%	4.4%	24.7%	587
Chinese	71.9%	7.3%	3.8%	17.1%	661
Other	57.6%	10.2%	4.7%	27.5%	363

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	83.3%	6.0%	1.0%	9.6%	612
Spanish	85.1%	5.3%	1.0%	8.6%	590
Vietnamese	78.0%	5.1%	1.5%	15.4%	740
Korean	88.2%	6.3%	1.0%	4.5%	842
Farsi	84.3%	4.8%	1.9%	8.9%	516
Arabic	83.2%	5.5%	1.5%	9.8%	531
Chinese	86.9%	5.2%	1.1%	6.7%	610
Other	80.3%	6.7%	3.5%	9.5%	315

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	76.7%	12.2%	2.9%	8.2%	621
Spanish	80.1%	7.7%	2.9%	9.3%	613
Vietnamese	78.2%	7.7%	1.9%	12.1%	725
Korean	73.6%	13.8%	4.6%	8.0%	864
Farsi	78.4%	9.9%	3.7%	8.0%	538
Arabic	74.5%	11.4%	2.7%	11.4%	553
Chinese	85.9%	5.3%	2.4%	6.3%	618
Other	82.9%	9.2%	3.5%	4.4%	315

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	0.8%	1.1%	6.2%	91.9%	632
Spanish	0.2%	0.3%	2.5%	97.1%	651
Vietnamese	2.6%	0.6%	3.1%	93.7%	772
Korean	0.8%	0.8%	6.5%	91.8%	846
Farsi	1.3%	1.0%	2.9%	94.8%	594
Arabic	5.0%	2.4%	1.0%	91.6%	582
Chinese	7.5%	2.3%	3.3%	86.8%	598
Other	2.2%	2.0%	8.1%	87.7%	358

Age Category:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	32.2%	3.4%	2.0%	62.4%	348
6-18 (Children)	33.0%	3.9%	2.5%	60.6%	1,077
19-64 (Adults/MCE)	43.2%	5.6%	4.2%	47.0%	2,093
65+ (Older Adults)	24.3%	4.3%	4.2%	67.2%	1,295

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	75.0%	9.8%	2.9%	12.2%	376
6-18 (Children)	72.5%	12.3%	4.7%	10.6%	1,137
19-64 (Adults/MCE)	43.6%	24.2%	9.3%	23.0%	2,190
65+ (Older Adults)	41.9%	19.2%	8.6%	30.3%	1,401

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	14.5%	10.4%	11.0%	64.1%	365
6-18 (Children)	22.7%	18.3%	17.2%	41.8%	1,117
19-64 (Adults/MCE)	18.0%	14.9%	20.8%	46.3%	2,142
65+ (Older Adults)	12.1%	10.1%	12.2%	65.6%	1,324

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	69.2%	7.0%	1.9%	21.9%	370
6-18 (Children)	77.9%	8.4%	3.2%	10.5%	1,148
19-64 (Adults/MCE)	62.2%	12.6%	5.7%	19.5%	2,211
65+ (Older Adults)	69.3%	4.9%	3.6%	22.2%	1,467

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	89.8%	3.6%	0.6%	6.1%	362
6-18 (Children)	90.2%	4.5%	0.9%	4.3%	1,084
19-64 (Adults/MCE)	80.5%	6.7%	1.7%	11.0%	2,061
65+ (Older Adults)	82.4%	5.2%	1.6%	10.8%	1,249

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	79.0%	6.4%	3.6%	11.0%	362
6-18 (Children)	83.2%	7.7%	2.4%	6.7%	1,110
19-64 (Adults/MCE)	70.7%	14.3%	4.3%	10.8%	2,105
65+ (Older Adults)	86.5%	5.3%	1.7%	6.5%	1,270

Visit a casino or gamble on the internet	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	3.0%	0.5%	1.6%	94.8%	368
6-18 (Children)	2.3%	0.6%	1.8%	95.3%	1,134
19-64 (Adults/MCE)	1.9%	1.0%	5.4%	91.7%	2,171
65+ (Older Adults)	3.2%	2.3%	4.6%	89.9%	1,360

Region:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	35.3%	5.4%	3.7%	55.6%	1,639
South	28.8%	4.2%	4.0%	62.9%	1,252
Central	38.8%	4.4%	3.4%	53.4%	1,910

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	51.8%	20.1%	8.0%	20.0%	1,757
South	47.7%	21.1%	8.0%	23.2%	1,345
Central	55.0%	16.6%	6.9%	21.5%	1,989

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	17.7%	13.8%	16.0%	52.5%	1,702
South	16.8%	13.2%	16.8%	53.3%	1,307
Central	17.1%	14.9%	17.9%	50.1%	1,927

Physical fitness	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	67.4%	10.2%	4.9%	17.5%	1,780
South	69.4%	8.8%	4.4%	17.4%	1,387
Central	67.9%	8.3%	3.7%	20.1%	2,017

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	86.8%	4.7%	0.8%	7.7%	1,668
South	86.0%	5.3%	1.8%	6.9%	1,230
Central	79.9%	6.6%	1.7%	11.8%	1,848

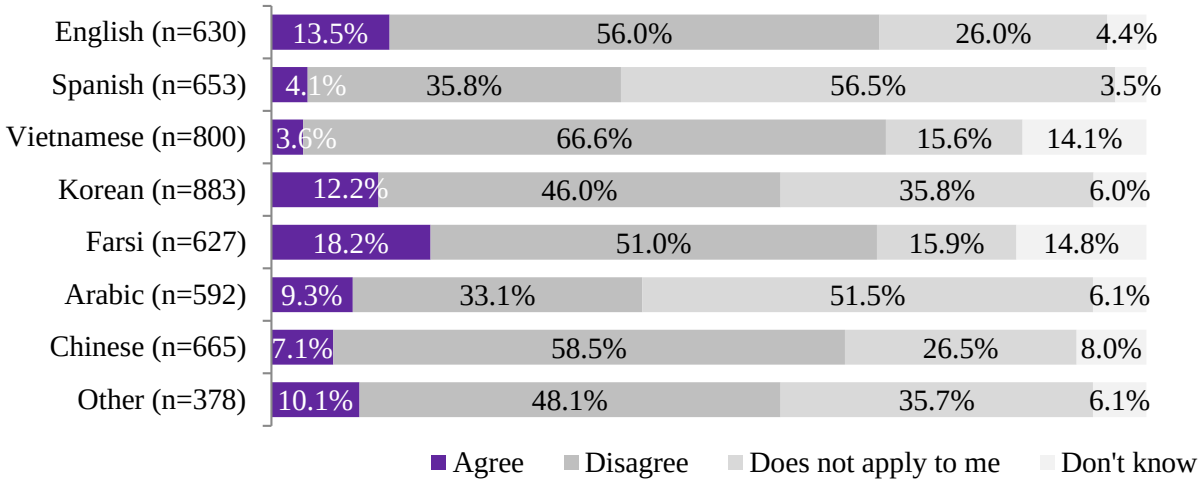
Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	76.2%	10.9%	3.8%	9.1%	1,694
South	81.0%	9.2%	3.3%	6.5%	1,263
Central	78.5%	9.2%	2.3%	9.9%	1,880

Visit a casino or gamble on the internet	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	1.5%	0.9%	4.5%	93.2%	1,726
South	4.0%	1.1%	3.7%	91.3%	1,327
Central	2.2%	1.7%	4.0%	92.1%	1,969

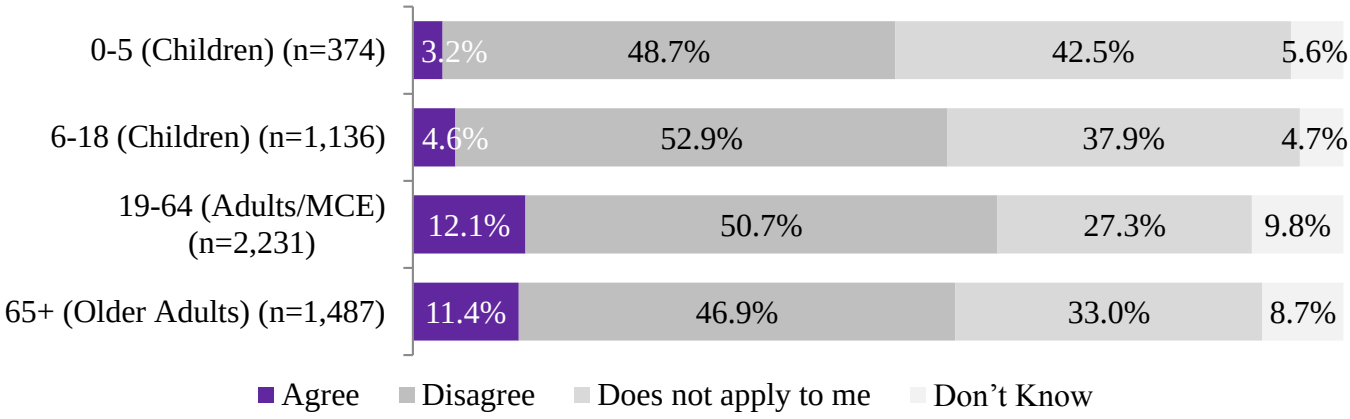
Exhibit 16. Feelings towards community and home enviroment:

Feeling lonely and isolated:

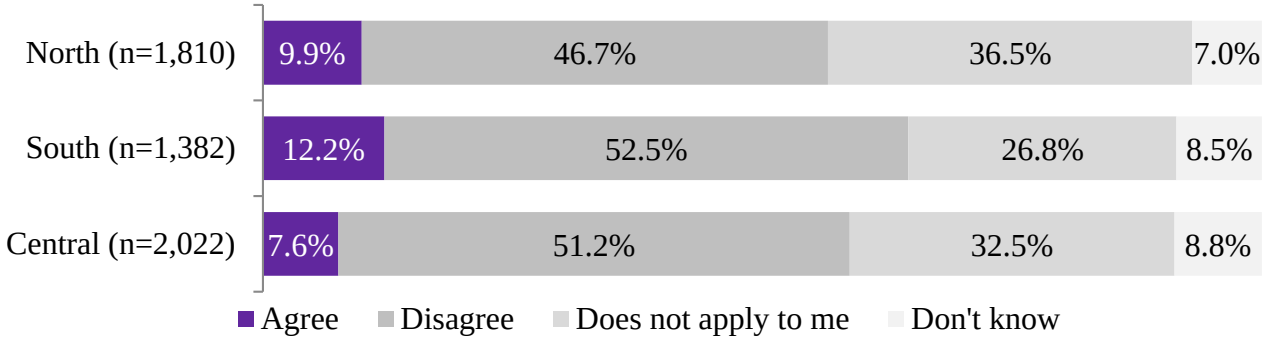
CalOptima language:



Age Category:

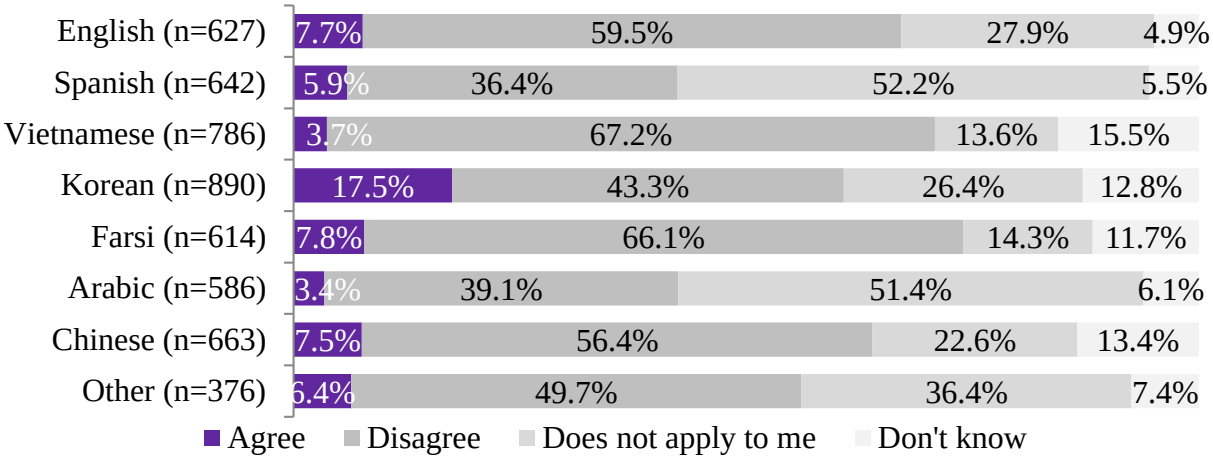


Region:

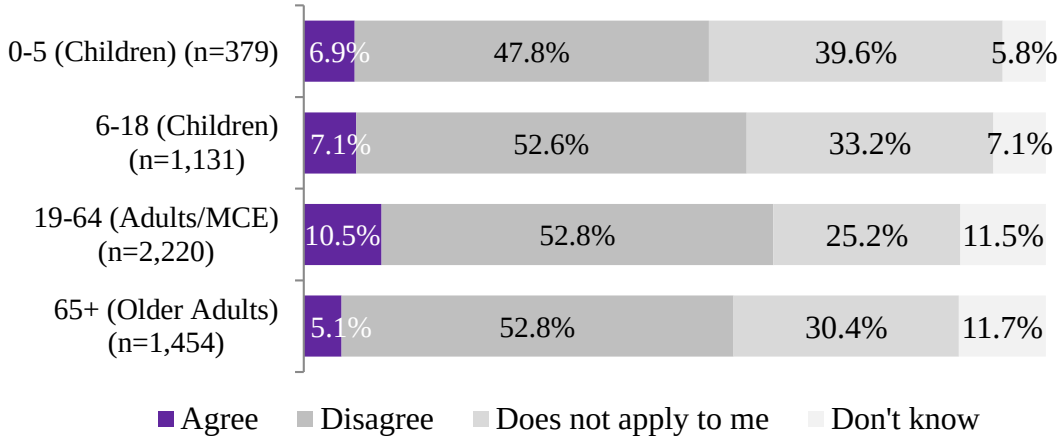


Feel not treated equally because of ethnic and culutral backgrounds:

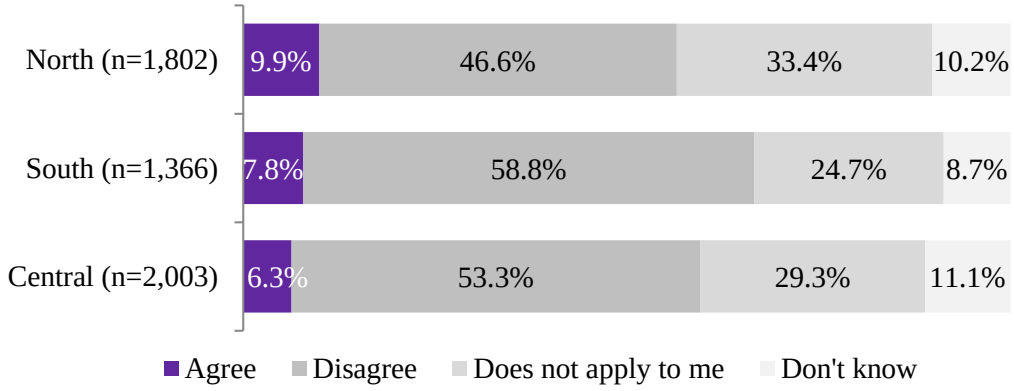
CalOptima language:



Age Category:

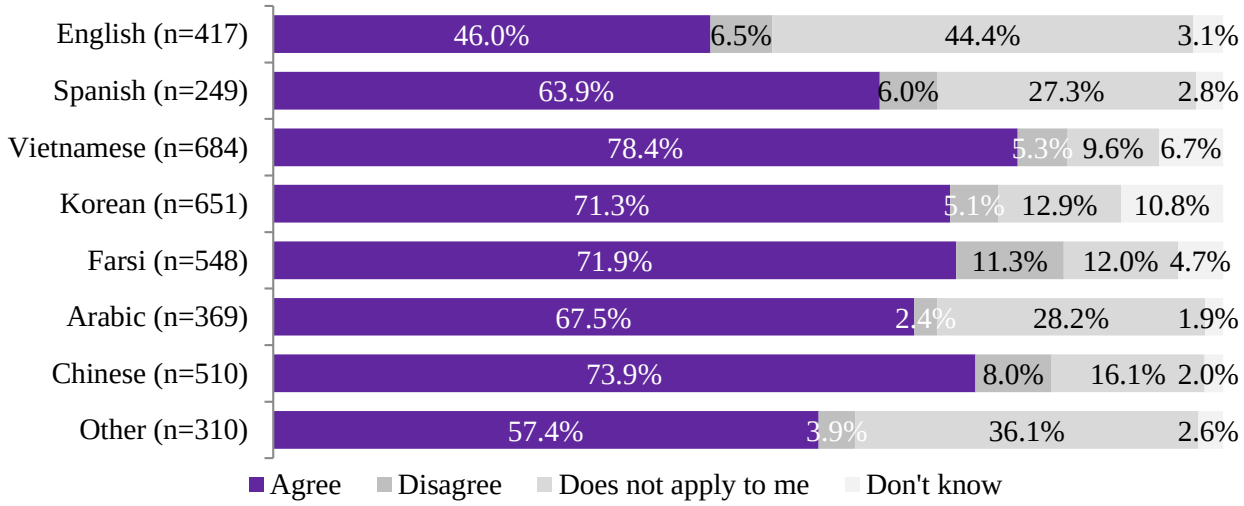


Region:



Feel child respects them as a parent[9]:

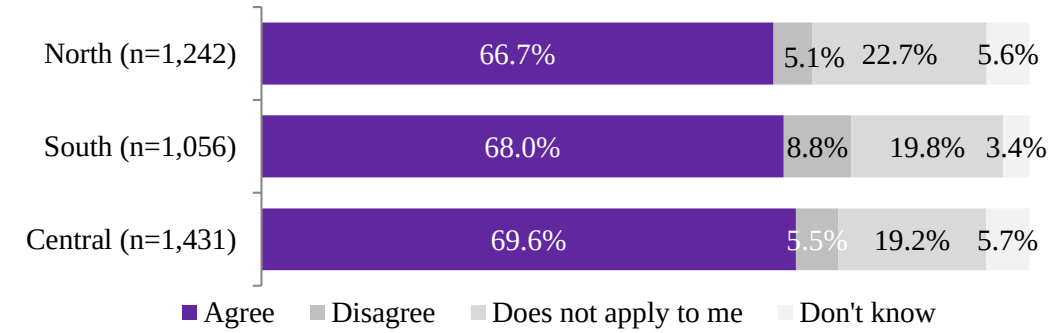
CalOptima language:



Age Category:



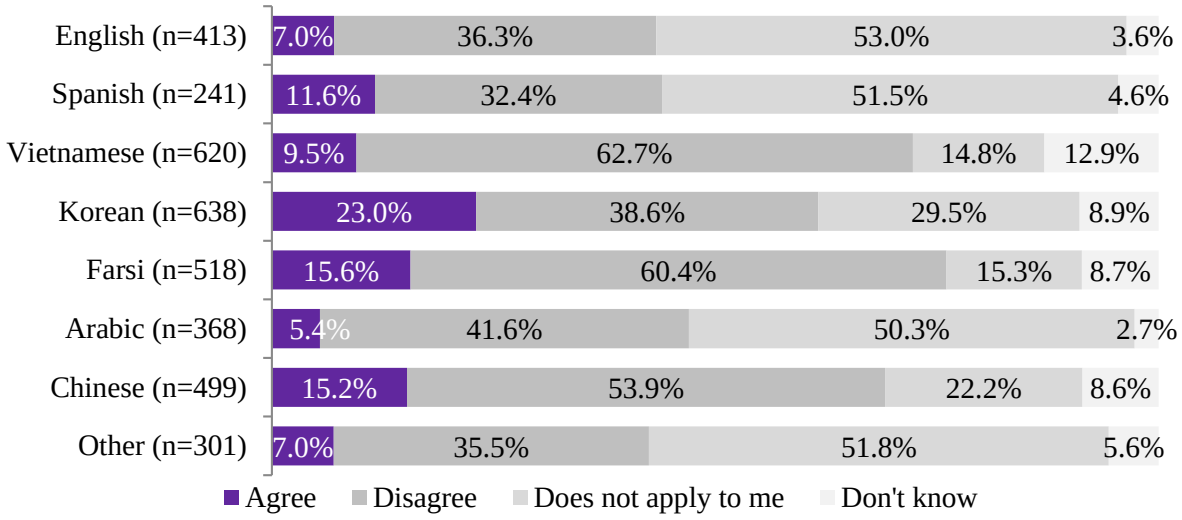
Region:



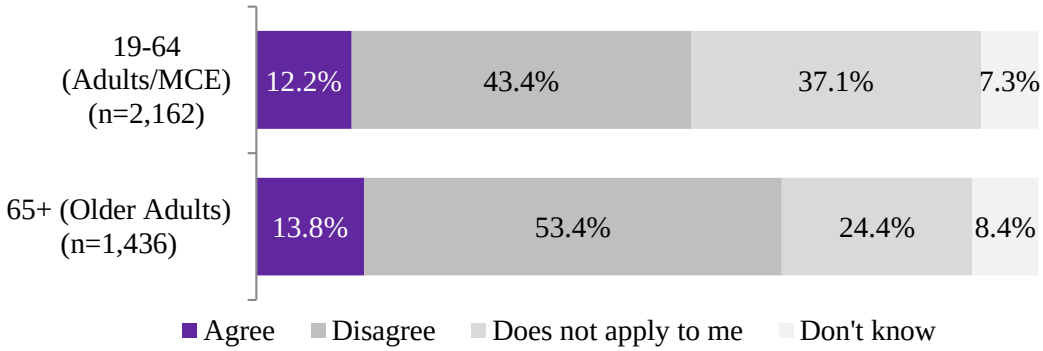
[9] Only reported those who are over 18 years old.

Feel child's attitudes and behavior conflict with cultural values[10]:

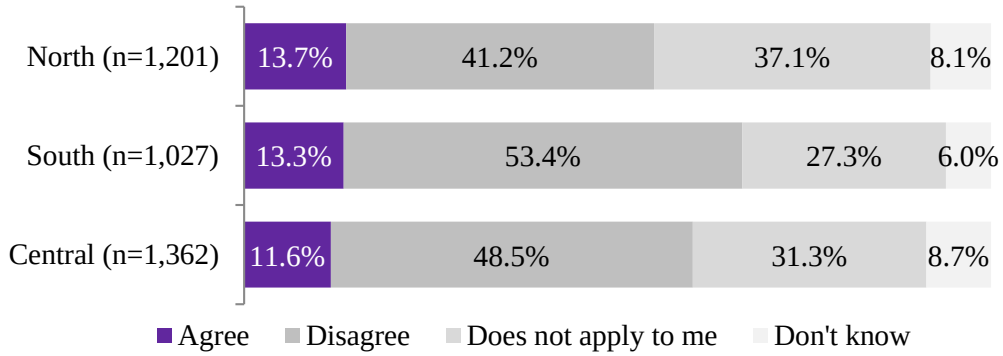
CalOptima language:



Age Category:



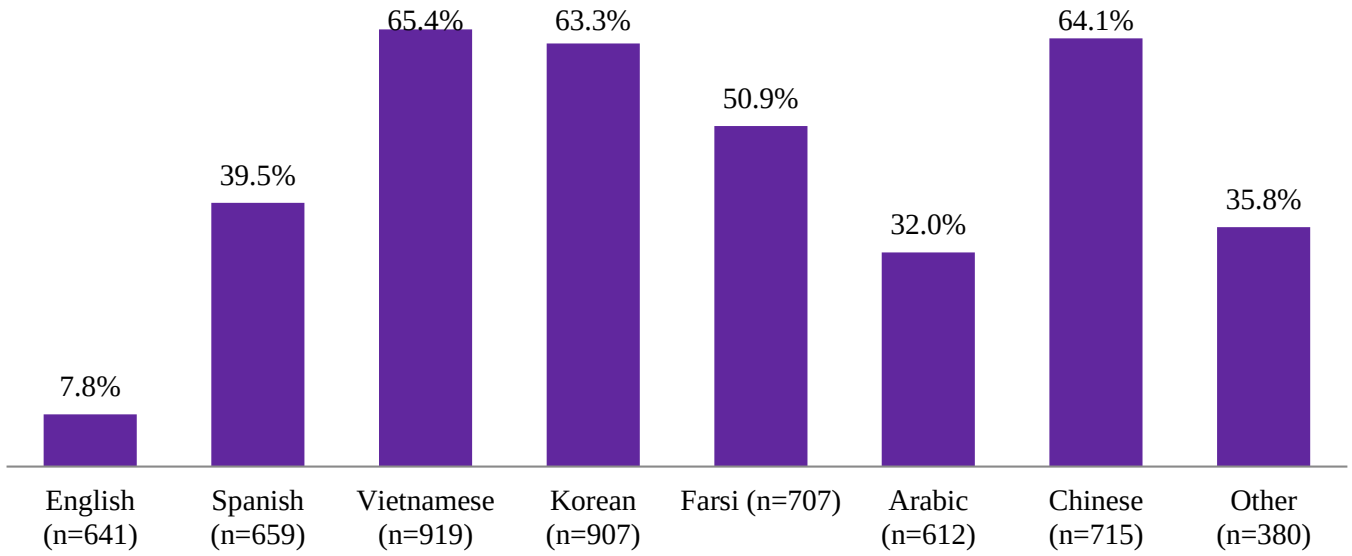
Region:



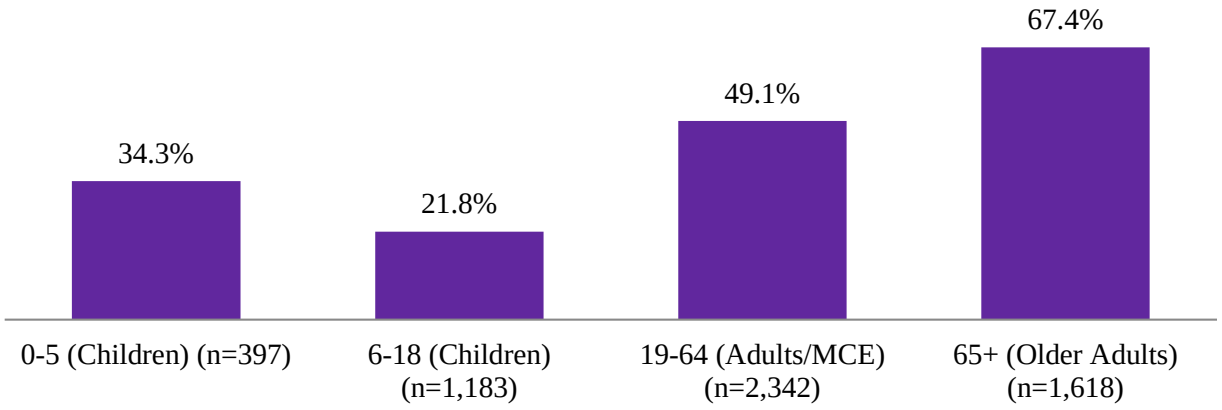
[10] Only reported those who are over 18 years old.

Exhibit 17. Members who reported that they speak English "not well":

CalOptima language:



Age Category:



Region:

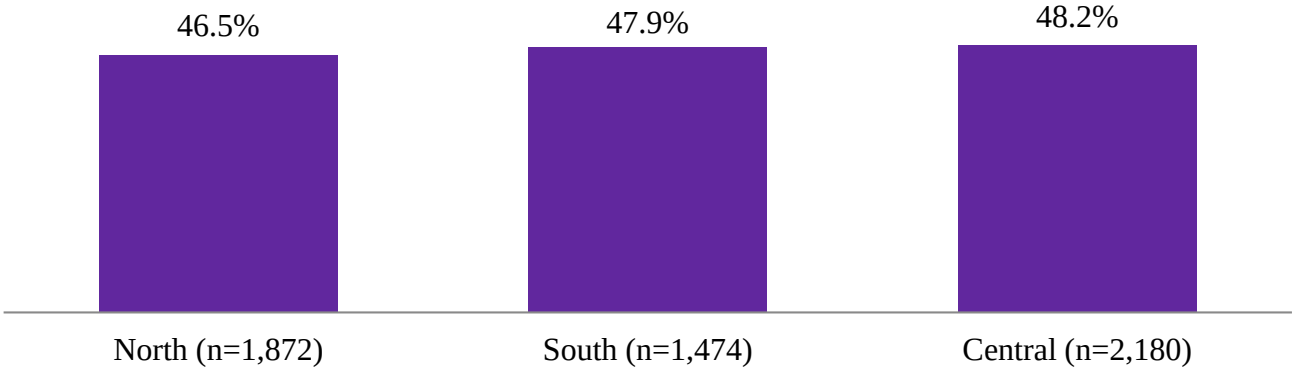


Exhibit 18. Employment status[11,12]

CalOptima language:

CalOptima language	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
English	36.7%	9.8%	7.2%	9.4%	13.4%	15.8%	20.4%	417
Spanish	21.7%	7.8%	11.6%	4.7%	21.3%	17.1%	28.3%	258
Vietnamese	32.1%	1.8%	12.1%	6.6%	24.4%	17.0%	20.0%	761
Korean	18.2%	11.6%	21.3%	6.9%	24.5%	10.0%	16.5%	638
Farsi	18.0%	4.4%	15.3%	7.6%	19.5%	26.5%	29.9%	616
Arabic	25.5%	4.2%	21.1%	9.4%	15.7%	11.9%	22.0%	427
Chinese	14.0%	3.8%	14.2%	4.9%	45.0%	6.8%	19.5%	529
Other	15.7%	3.4%	8.9%	3.7%	37.5%	10.2%	30.8%	325

Age Category:

Age Category	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
19-64 (Adults/MCE)	35.8%	8.3%	17.5%	10.9%	5.9%	17.6%	15.3%	2,370
65+ (Older Adults)	4.1%	1.7%	10.1%	0.7%	53.7%	10.5%	33.3%	1,601

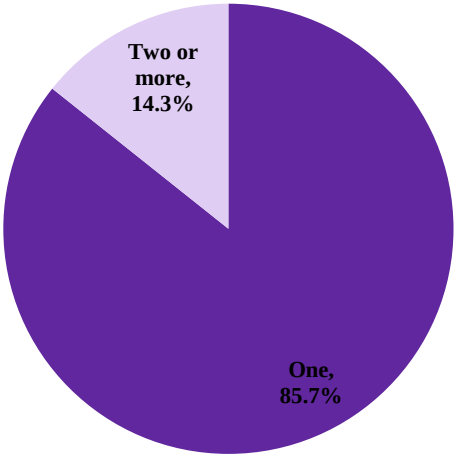
Region:

Region	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
North	24.0%	6.7%	15.9%	6.7%	23.6%	12.7%	22.5%	1,269
South	17.3%	6.6%	16.7%	7.3%	26.6%	17.3%	22.1%	1,129
Central	26.1%	4.0%	11.7%	6.5%	25.6%	14.7%	23.2%	1,561

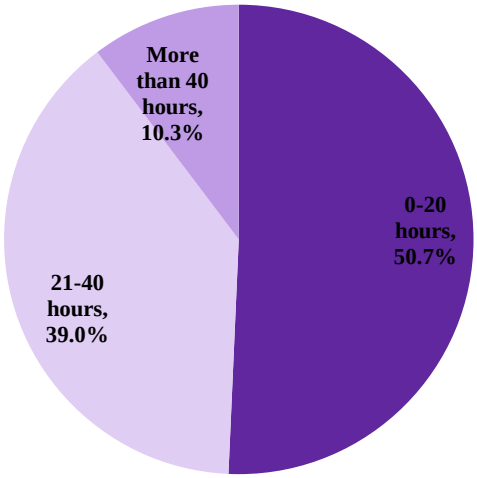
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]

Number of jobs members have

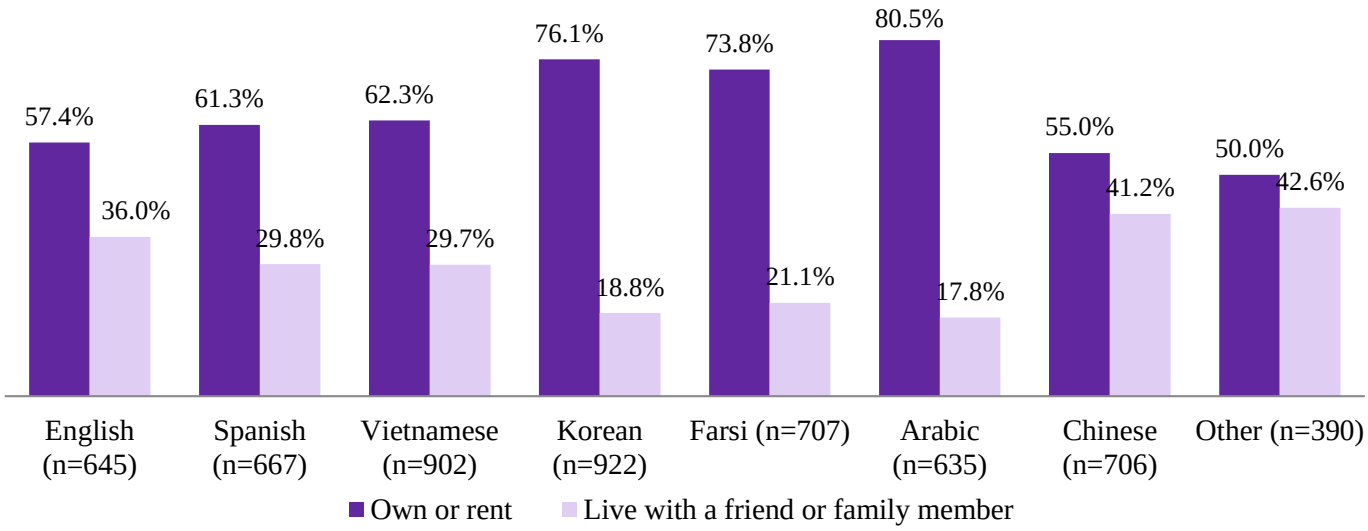


Number of hours that members work each week

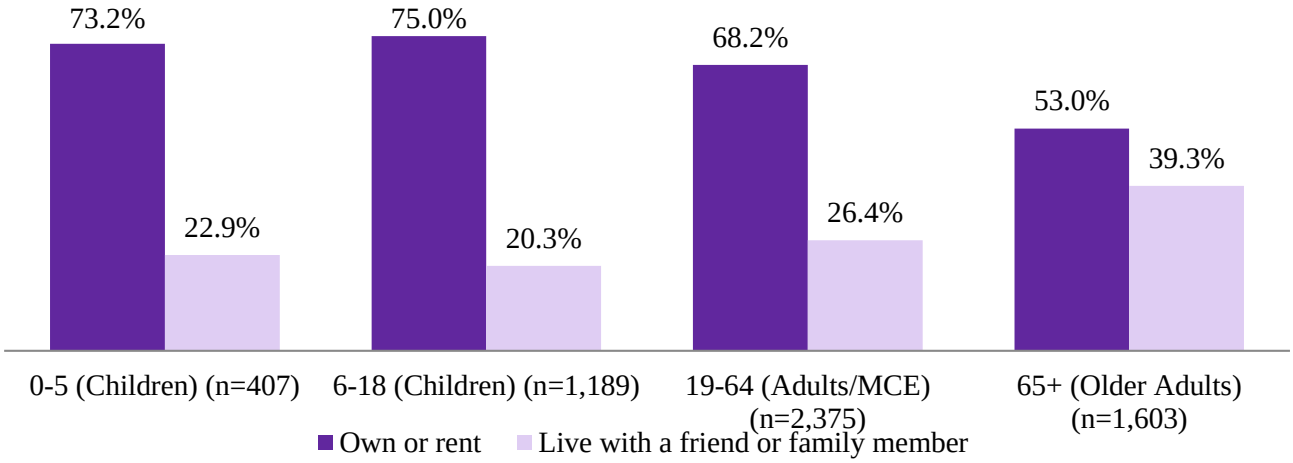


[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

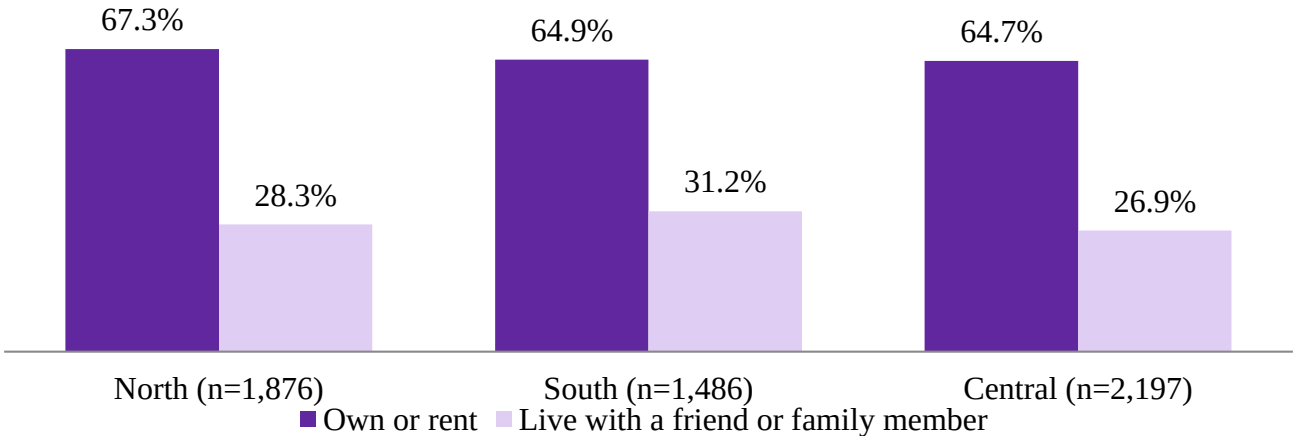
Exhibit 20. Members' living situation[14]



Age Category:



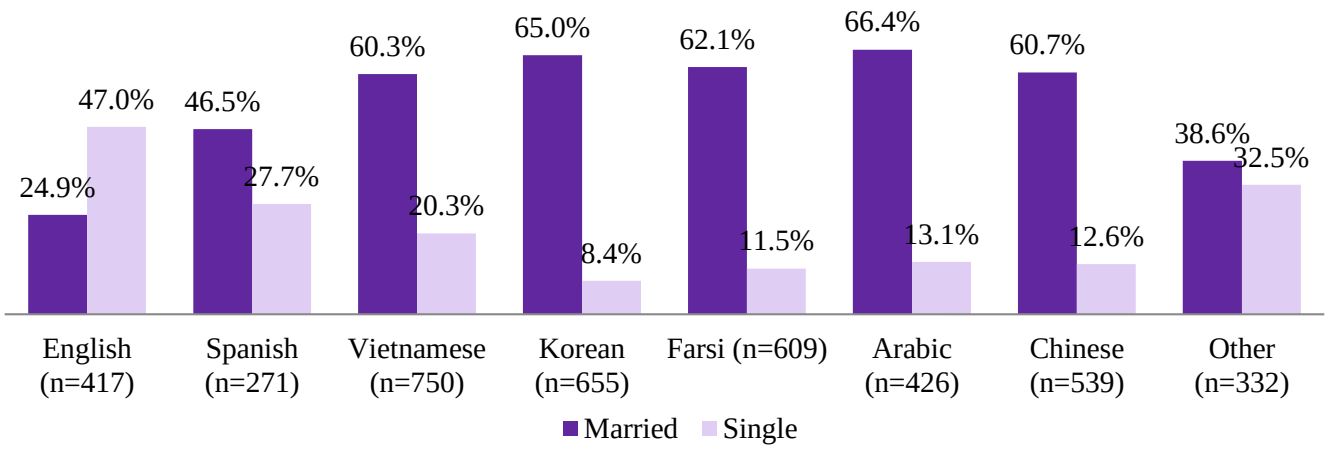
Region:



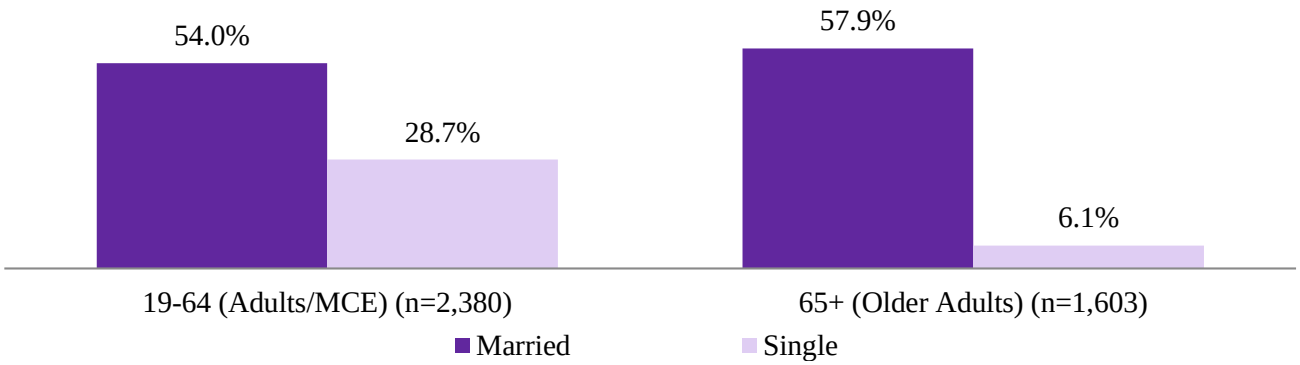
[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

Exhibit 21. Marital status of members[15],[16]

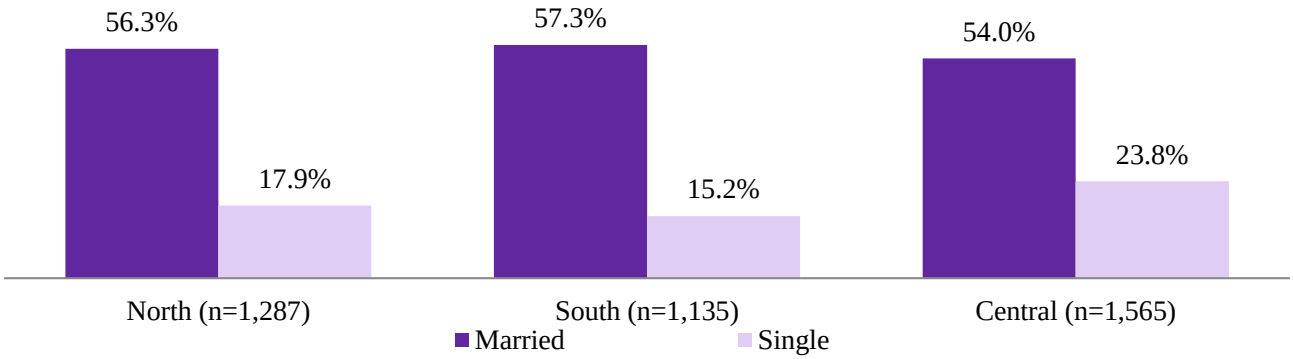
CalOptima language:



Age Category:



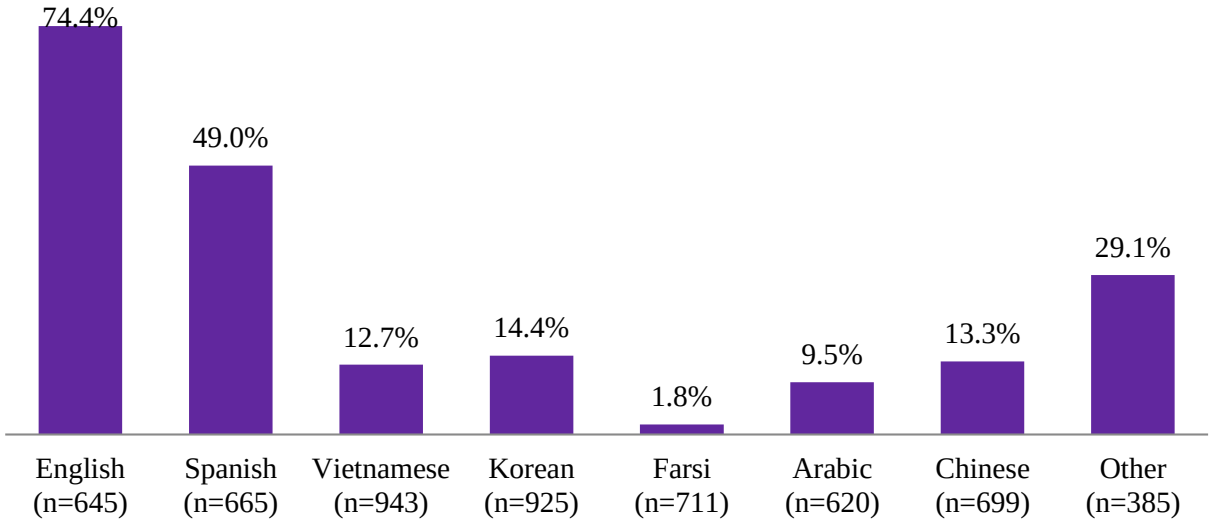
Region:



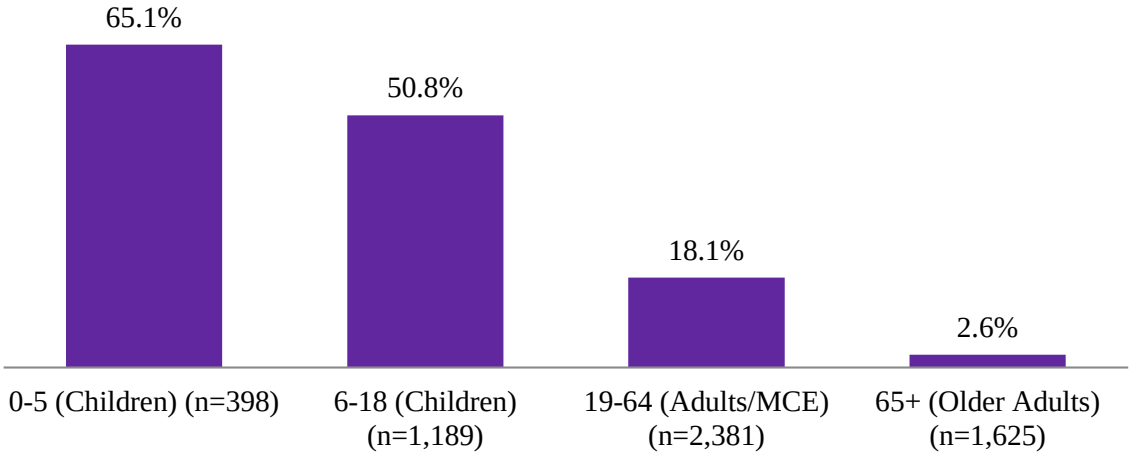
[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

Exhibit 22. Percent of members who were born in the United States:

CalOptima language:



Age Category:



Region:

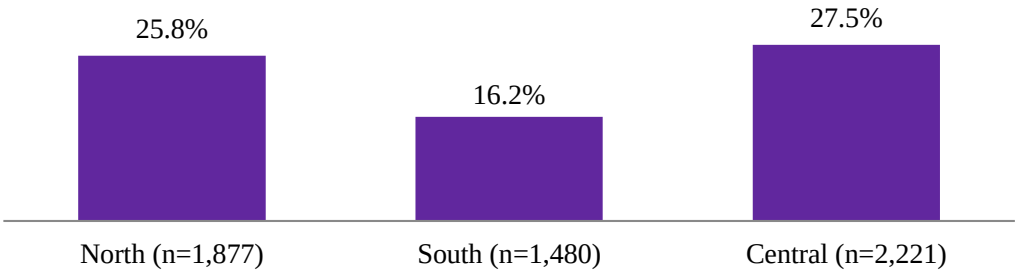
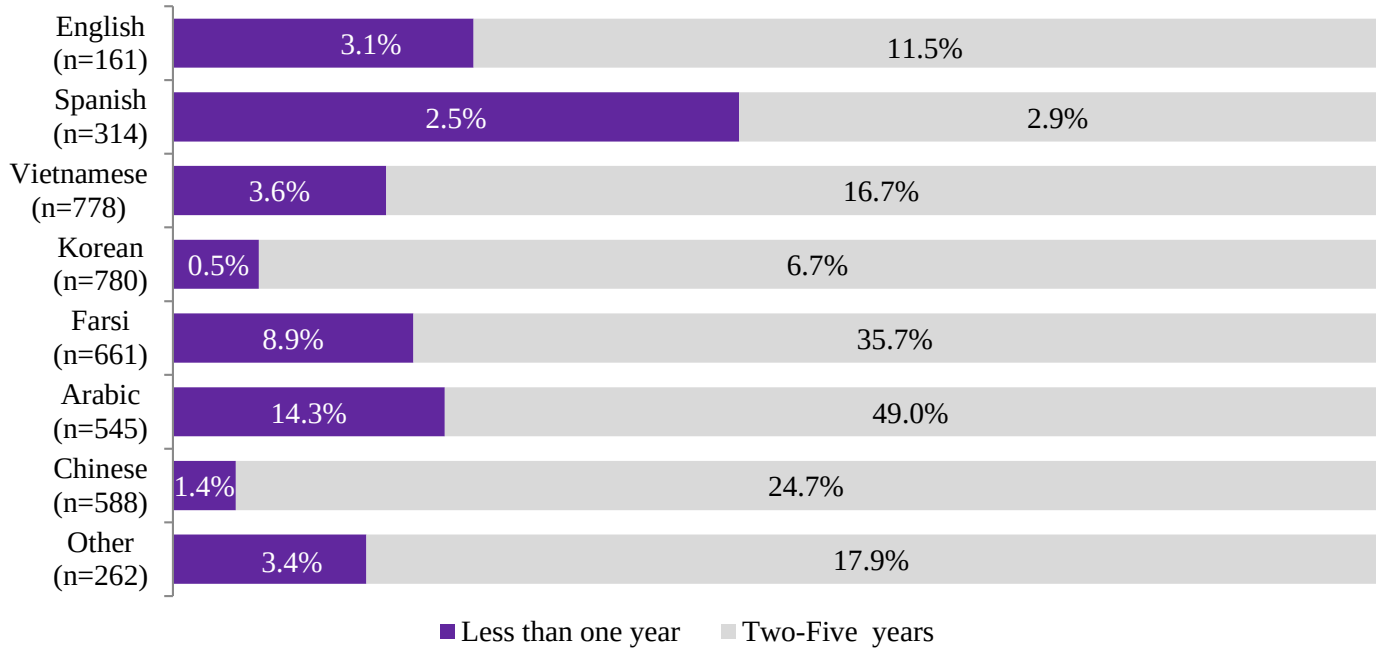
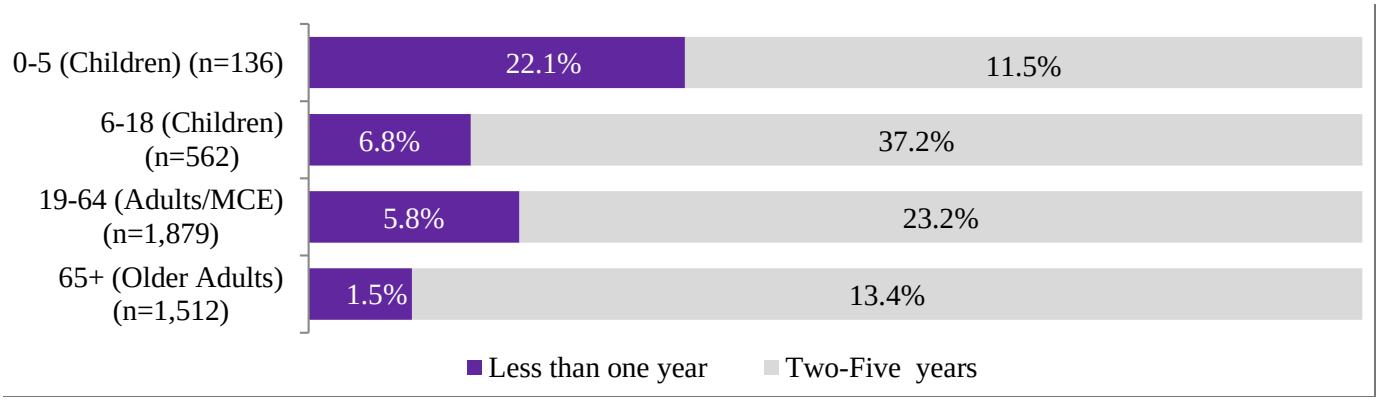


Exhibit 23. Length of time lived in the United States of those not born in the United States

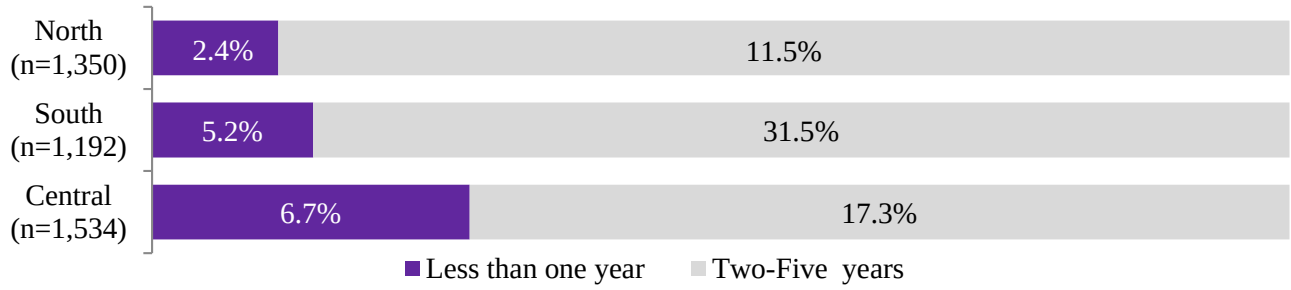
CalOptima language:



Age Category:



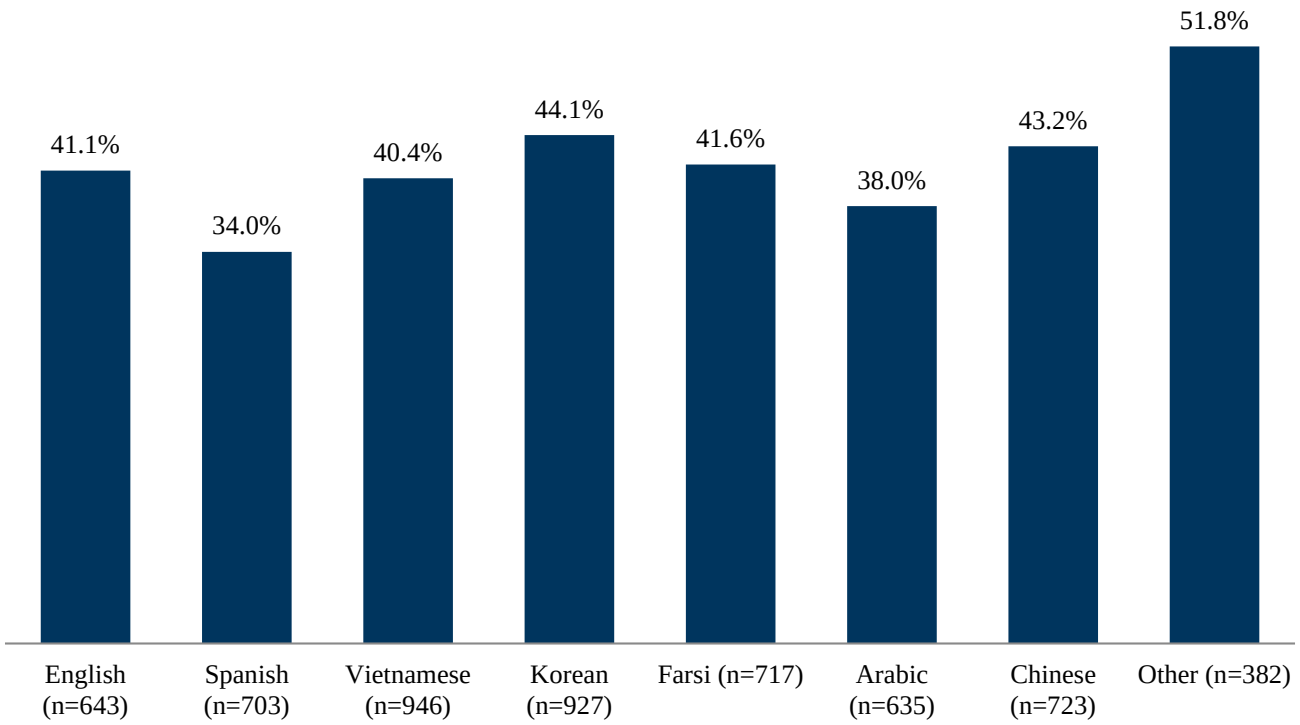
Region:



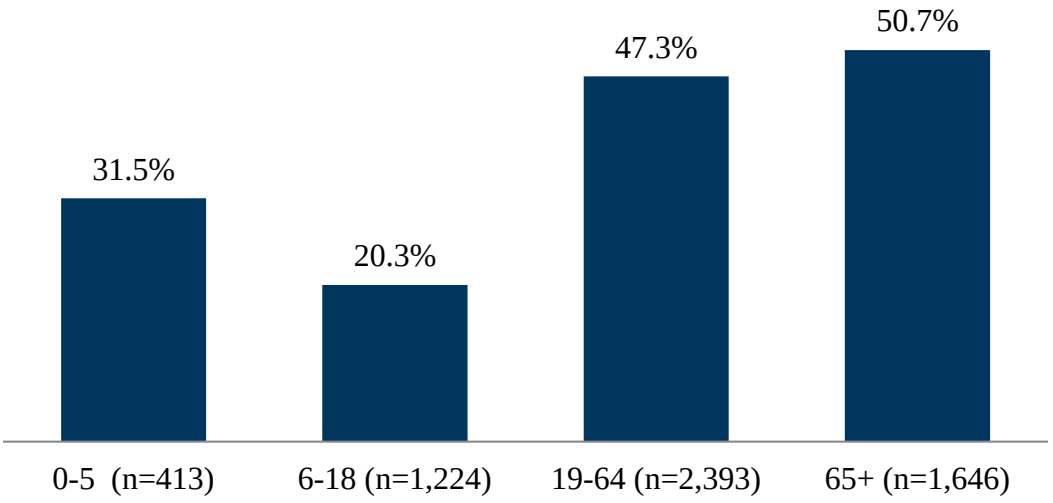
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:



Age Category:



Region:

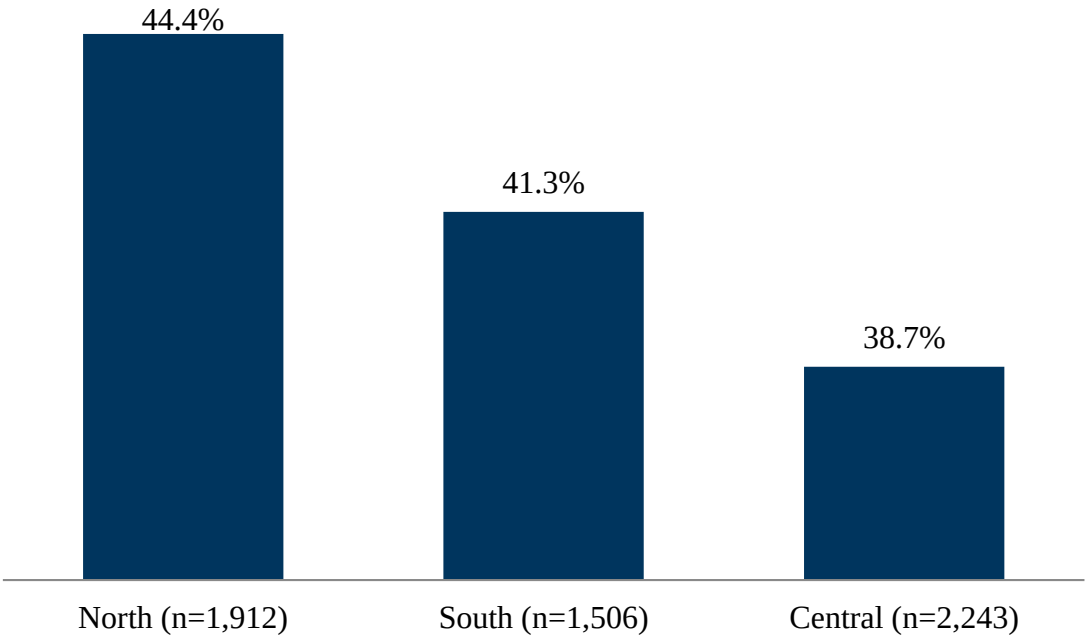


Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]

CalOptima Language:

CalOptima Language	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
English	43.8%	28.3%	6.6%	8.1%	258
Spanish	39.5%	17.6%	4.9%	12.2%	205
Vietnamese	26.6%	15.7%	5.0%	13.0%	338
Korean	64.2%	35.3%	4.1%	5.1%	391
Farsi	53.1%	23.8%	5.1%	8.1%	273
Arabic	62.9%	16.3%	1.8%	11.8%	221
Chinese	40.6%	21.1%	7.7%	14.1%	298
Other	33.1%	23.2%	5.5%	12.7%	181

Age Category:

CalOptima Age Category	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
0-5 (Children)	19.5%	23.7%	3.4%	14.4%	118
6-18 (Children)	34.7%	25.6%	1.8%	15.1%	219
19-64 (Adults/MCE)	52.7%	27.3%	4.1%	9.0%	1,062
65+ (Older Adults)	19.5%	23.7%	3.4%	14.4%	766

[17] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

[18] Only reported those who have not seen a dentist within the past 12 months.

Region:

CalOptima Region	Cost	Don't have/know dentist	No transportation	Don't know	n
	%	%	%	%	
North	48.9%	22.3%	5.5%	9.9%	798
South	51.6%	28.2%	4.6%	9.4%	585
Central	39.2%	20.9%	5.2%	11.3%	776

Exhibit 26. Days per week member had at least one drink of alcoholic beverage during the past 30 days [19]

CalOptima language:

CalOptima Language	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
English	71.7%	19.6%	4.0%	2.0%	2.7%	403
Spanish	83.5%	10.4%	1.3%	0.9%	3.9%	230
Vietnamese	81.3%	10.7%	1.9%	1.8%	4.3%	738
Korean	77.1%	15.5%	3.0%	1.5%	2.9%	593
Farsi	74.8%	19.3%	1.2%	0.2%	4.4%	497
Arabic	87.6%	4.5%	0.6%	0.8%	6.5%	355
Chinese	84.9%	8.0%	1.2%	0.6%	5.4%	503
Other	83.7%	7.7%	1.6%	1.3%	5.8%	312

Age Category:

CalOptima Age Category	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
19-64 (Adults/MCE)	78.7%	13.0%	2.3%	1.0%	4.9%	2,163
65+ (Older Adults)	82.2%	11.4%	1.4%	1.4%	3.5%	1,468

[19] Only reported those who are 18 years or older.

Region:

CalOptima Region	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
North	81.1%	11.9%	1.2%	1.5%	4.3%	1,156
South	79.5%	14.5%	1.8%	0.7%	3.5%	1,000
Central	79.7%	11.4%	2.5%	1.3%	5.1%	1,465

January 2018

CalOptima Member Survey Data Book:

Weighted Population Estimates

harder + co | community research

CalOptima A Public Agency Better. Together.

Navigating the Healthcare System

Exhibit 27. Percent who report at least one person as their doctor (n=5,749)

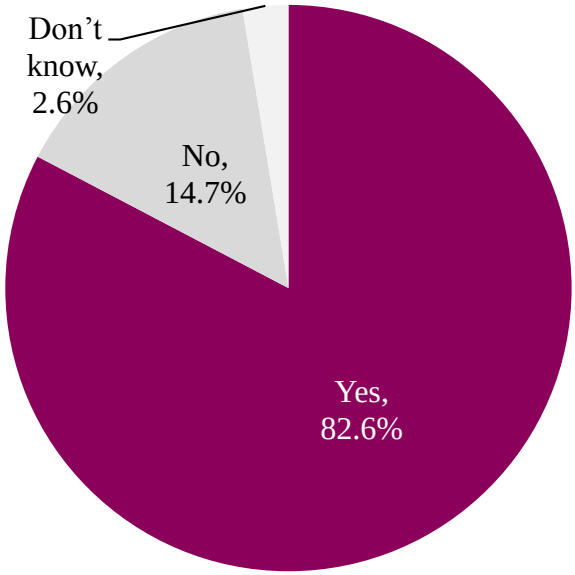


Exhibit 28. Where respondents go to see their doctor (n=5,743)

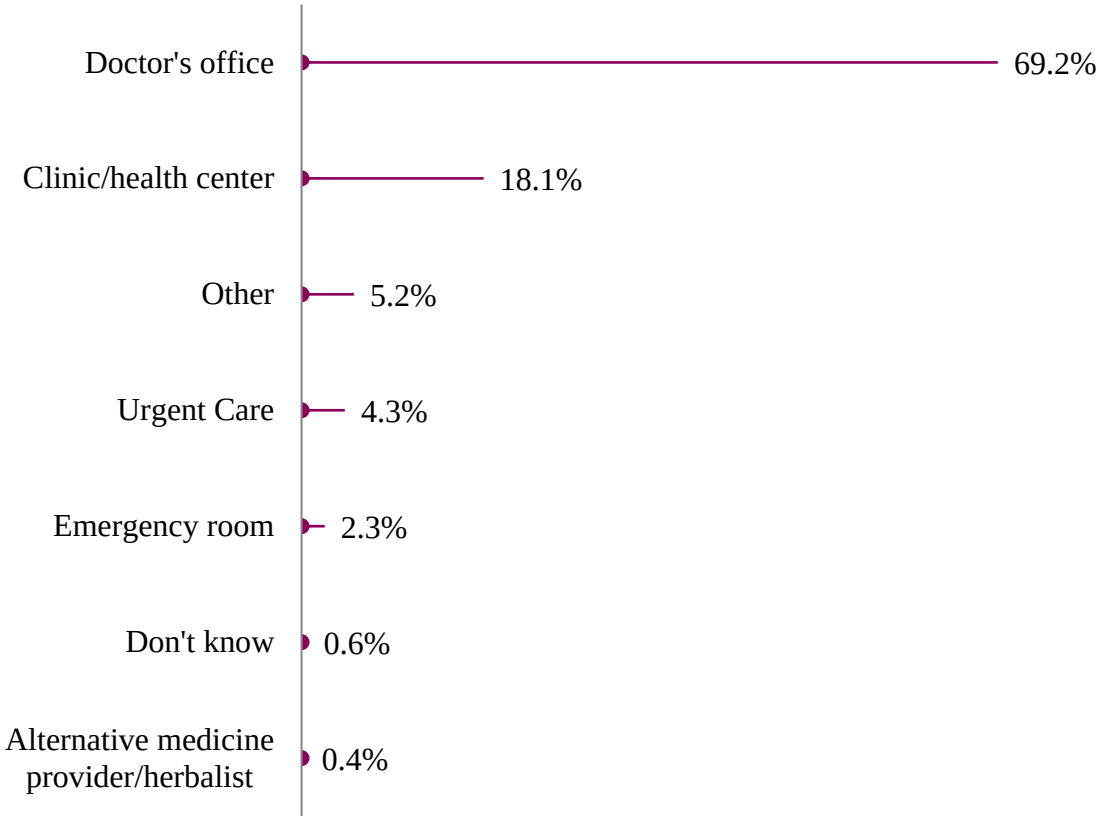


Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

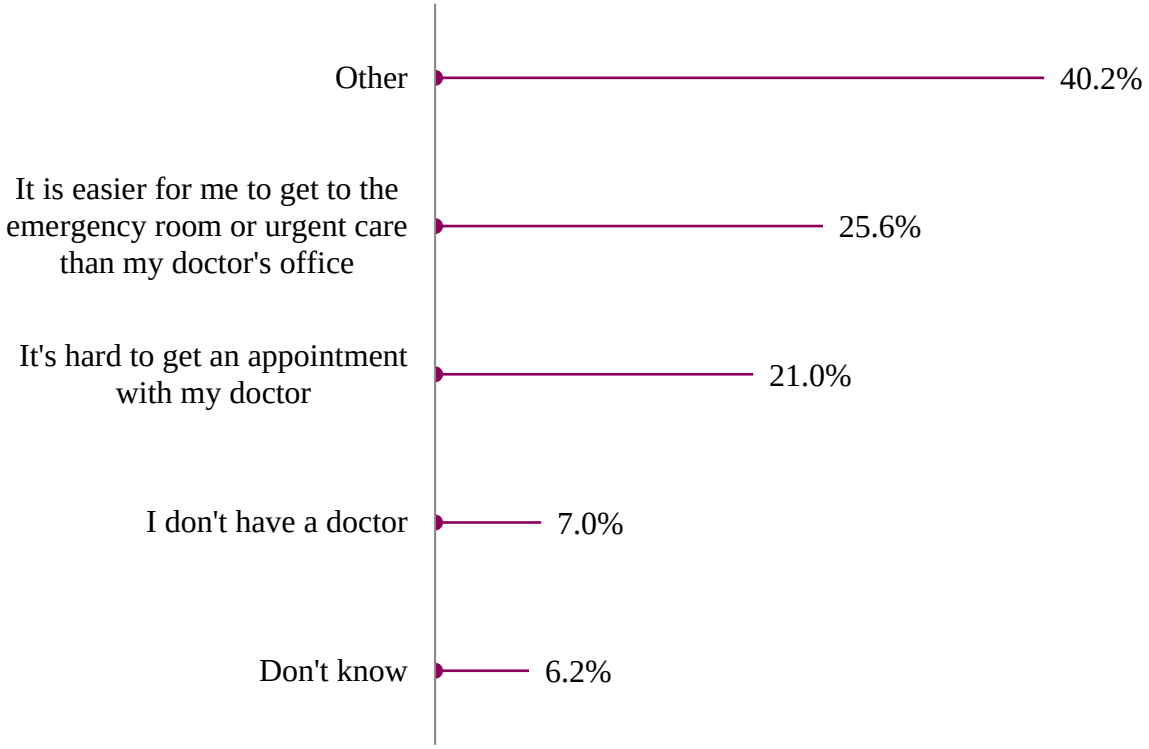


Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]

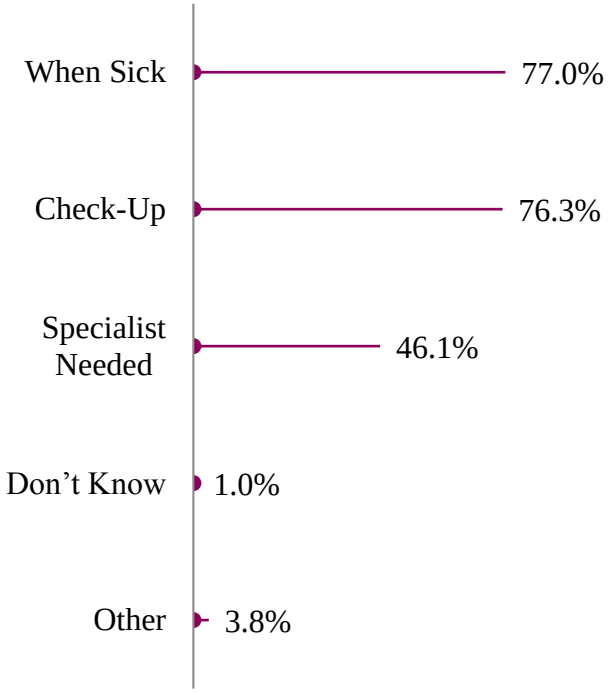
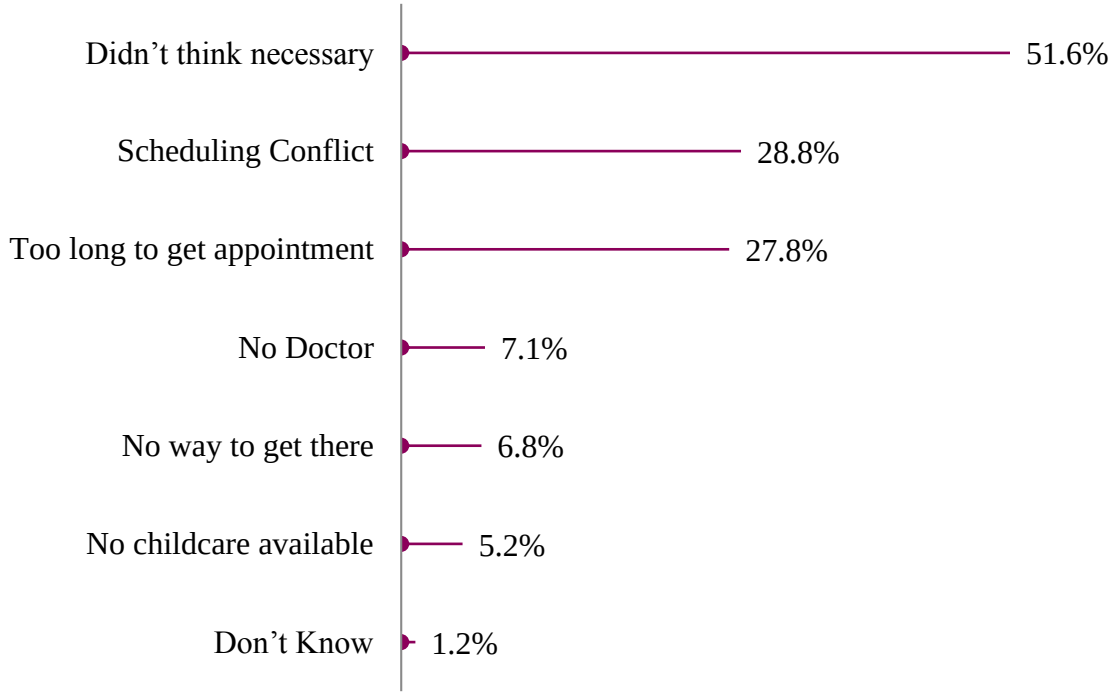


Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]



[20] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[21] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 32. When do members make an appointment to see a specialist (n=5,590)[22]

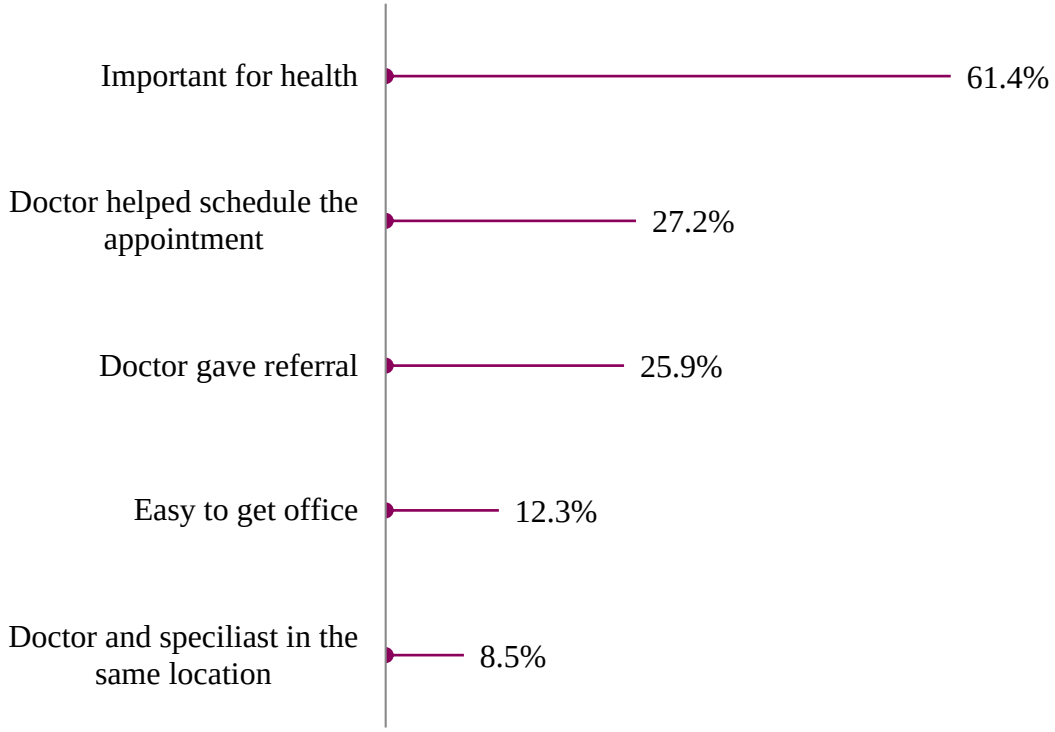
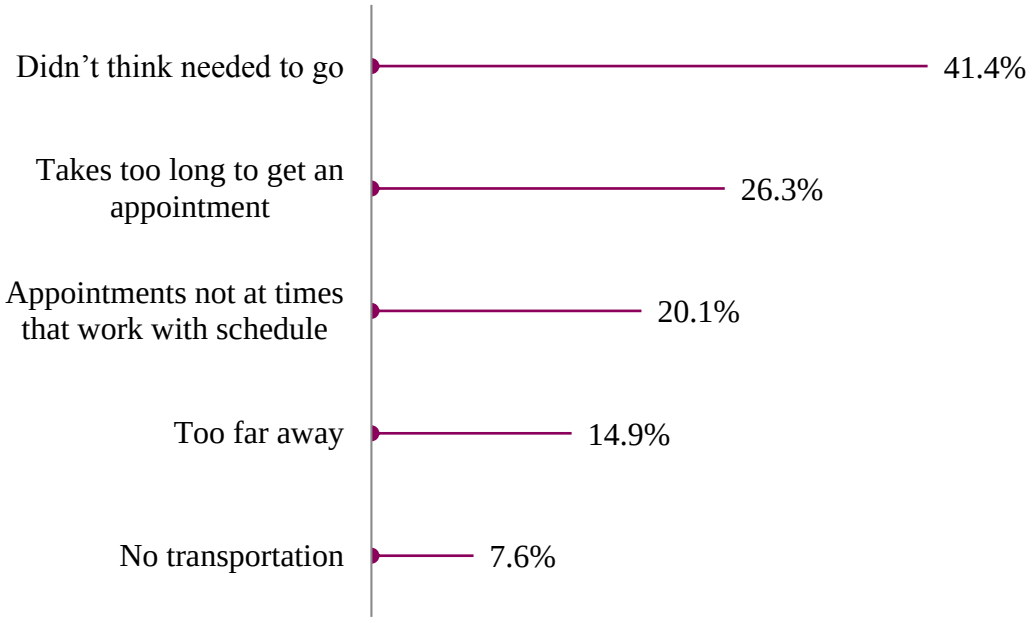
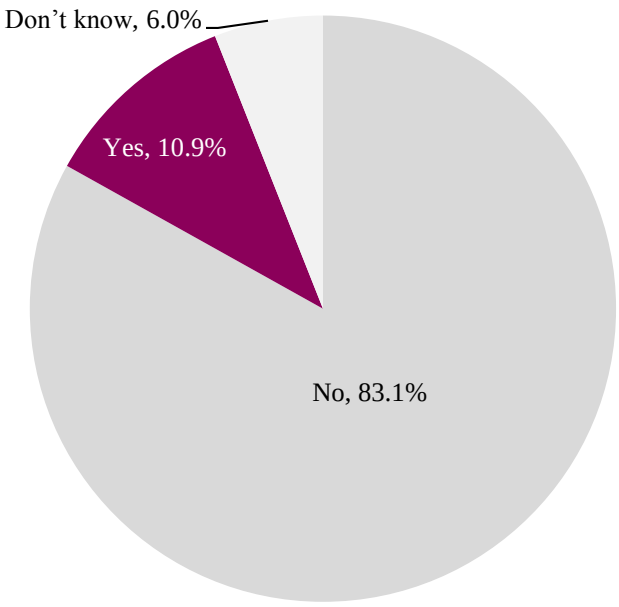


Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]



[22] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[23] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 34. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor (n=4,955)



Social and Emotional Well-Being

Exhibit 35. Percent of members who indicated they needed to see a mental health specialist (n=5,723)

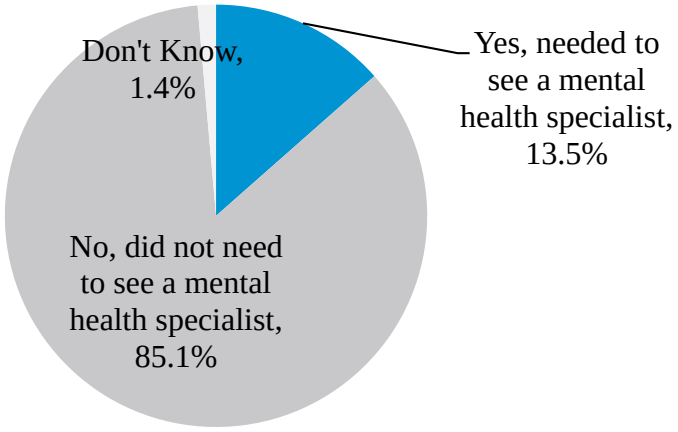


Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)

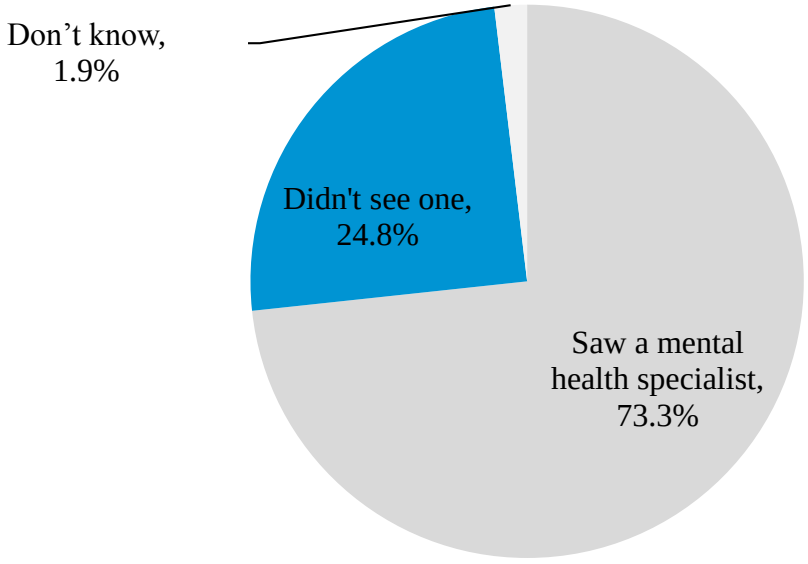


Exhibit 37. Reasons why members didn't see mental health specialist[24]

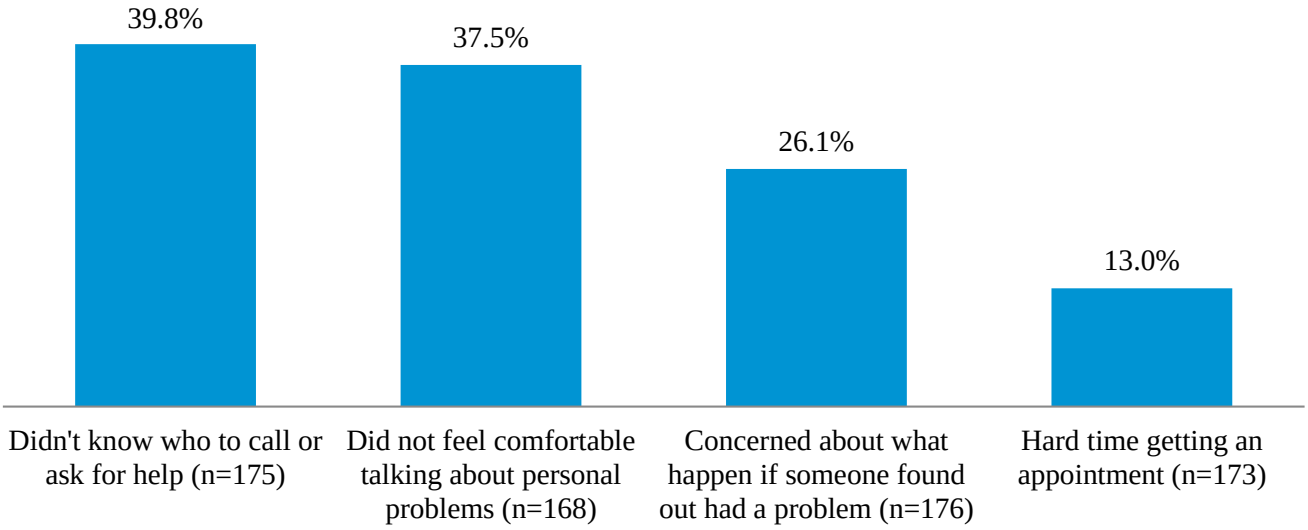
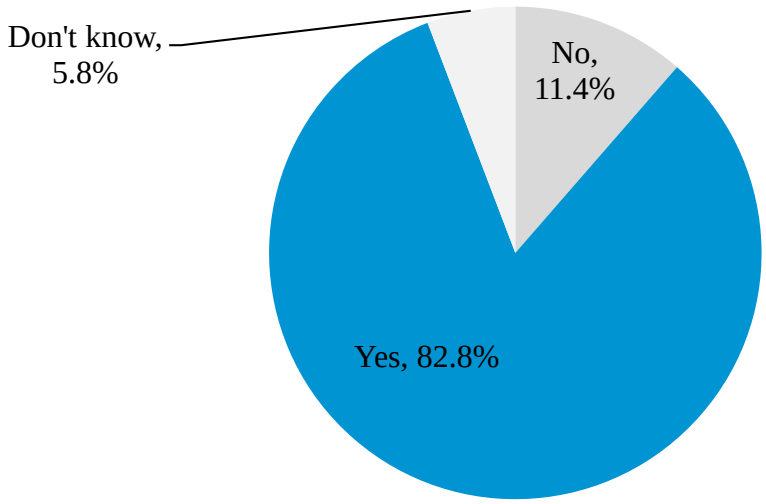


Exhibit 38. Percent of members who can share their worries with family members (n=5,670)



[24] Among those who indicated that they needed to see a mental health specialist but did not see one.

Social Determinants of Health

Exhibit 39. Percent of members who needed help with basic needs in the past 6 months:

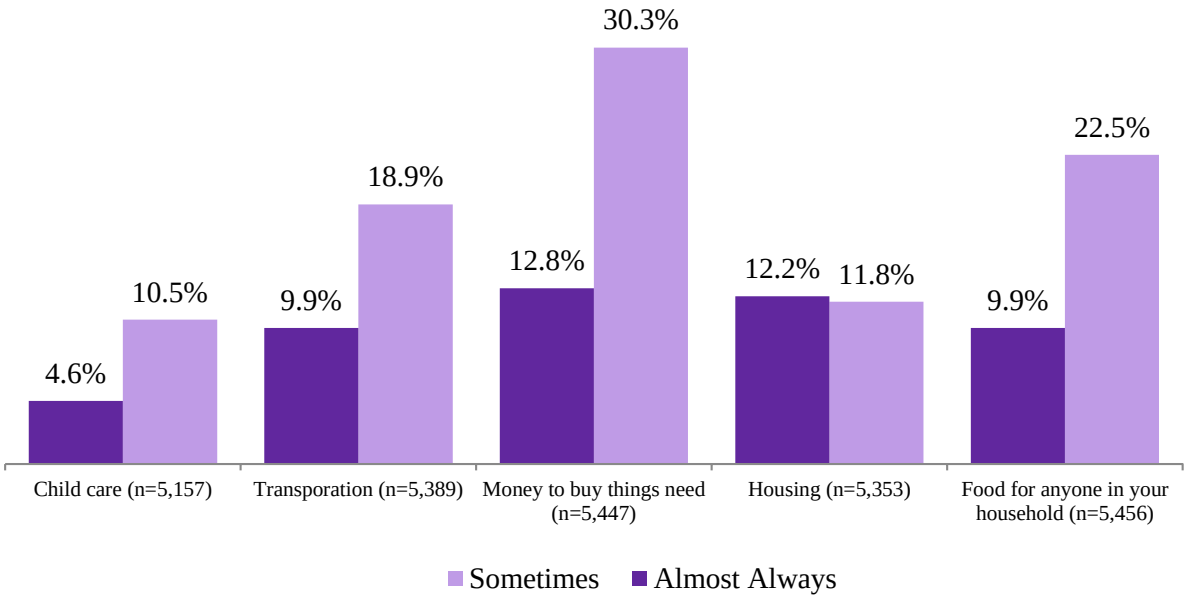


Exhibit 41. Percent of members who receive public benefits (n=5,117):

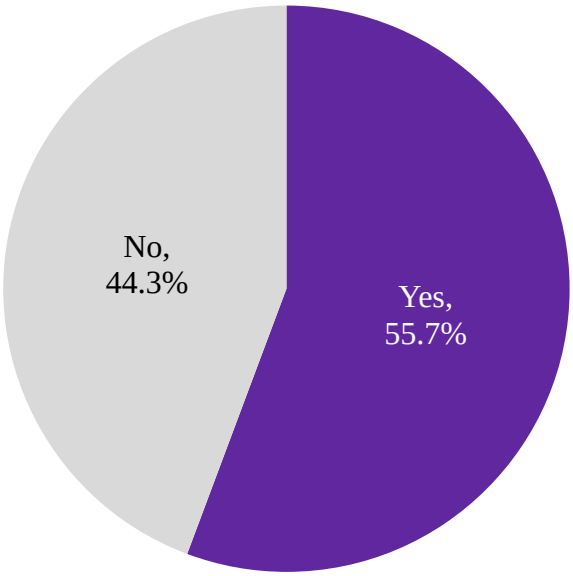
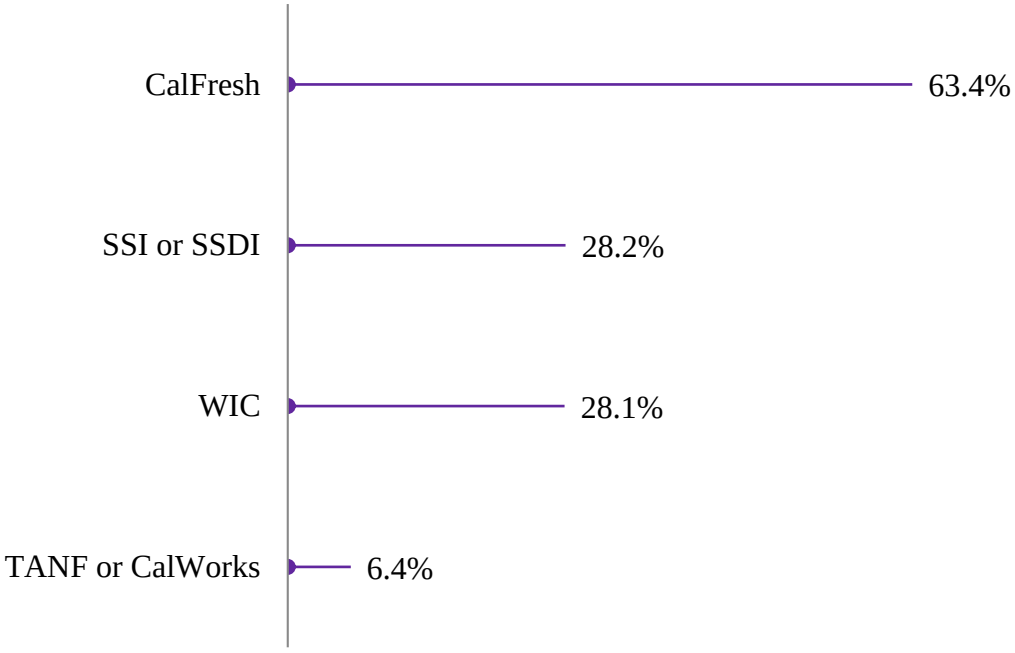


Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:

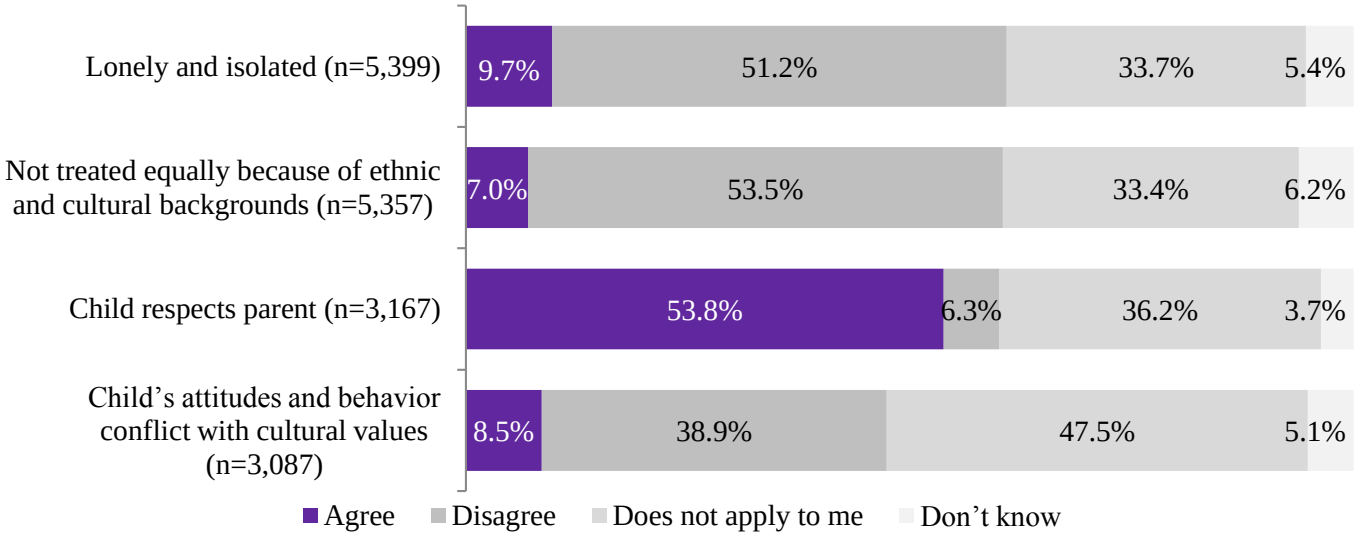


[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

Exhibit 43. Personal activities members participant in:

	Once a week	Once a month	Once in the last 6 months	Never	n
Care for a family member	36.2%	5.6%	5.1%	53.1%	5,209
Fun with others	61.9%	17.0%	6.6%	14.6%	5,396
Volunteer or Charity	16.4%	14.2%	17.3%	52.1%	5,288
Physical fitness	68.4%	10.2%	4.8%	16.7%	5,393
Attend religious centers	48.7%	11.1%	10.8%	29.4%	5,470
Get enough sleep	83.5%	5.8%	1.1%	9.6%	5,119
Enough time for self	77.4%	10.6%	3.1%	8.8%	5,209
Enough time for family	81.5%	8.5%	3.1%	6.9%	5,274
Gambling activities	0.9%	0.8%	4.8%	93.5%	5,378

Exhibit 44. Feelings towards community and home enviroment[26]:



[26] Only reported for those over 18 years old for "Child respects parent" and "Child's attitudes and behavior conflict with cultural values."

Exhibit 45. How well members speak English (n=5,549)

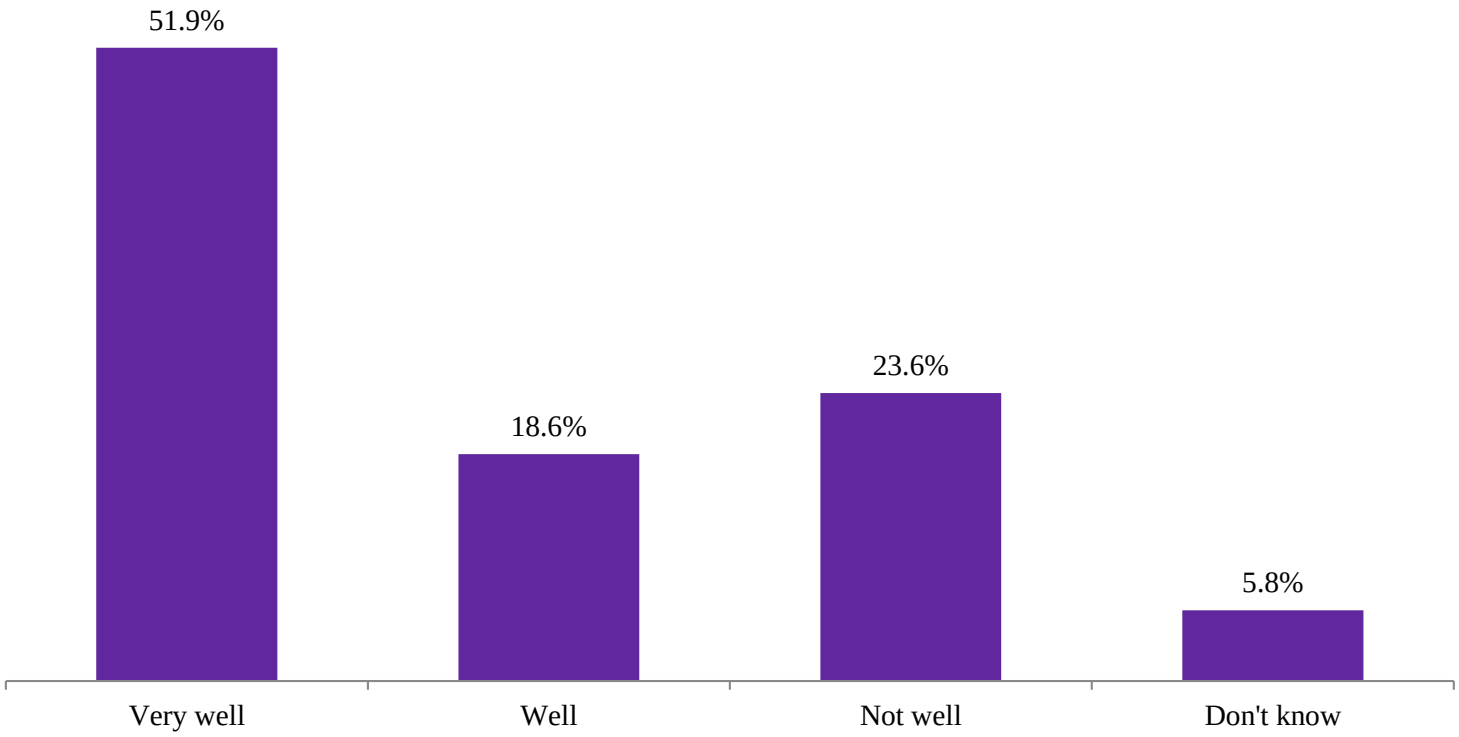


Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]

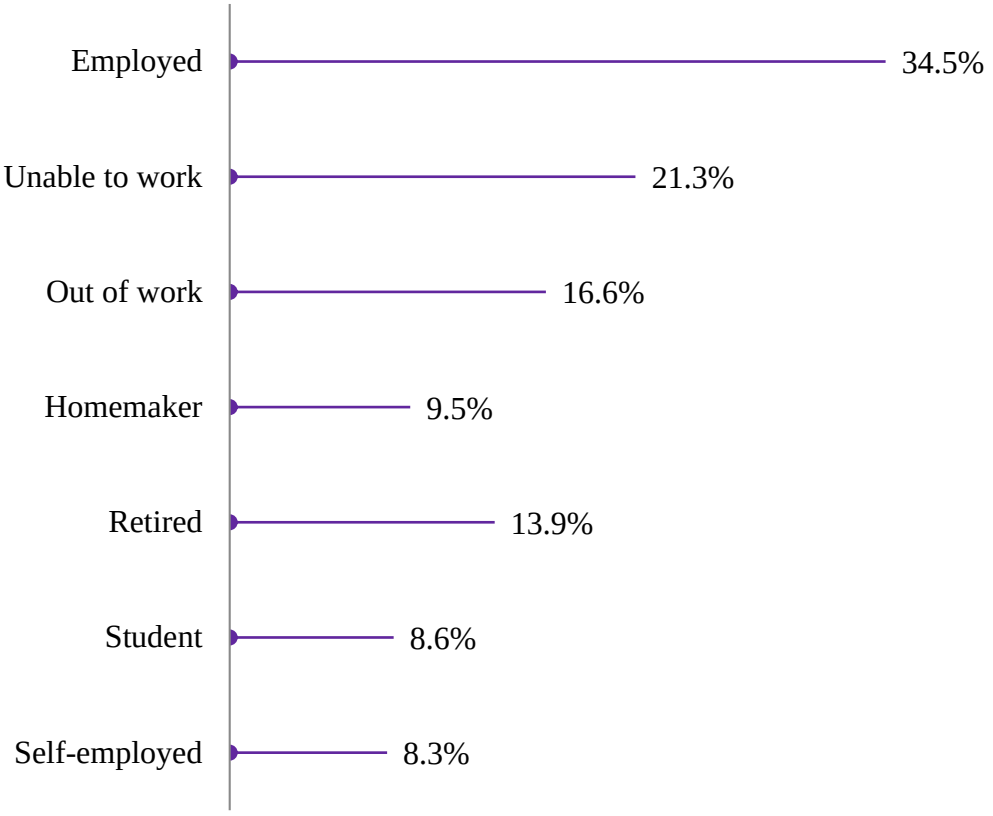
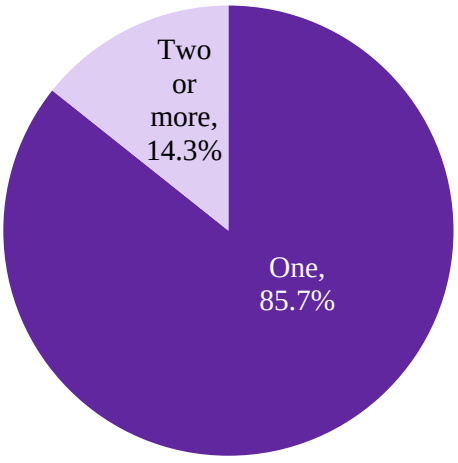
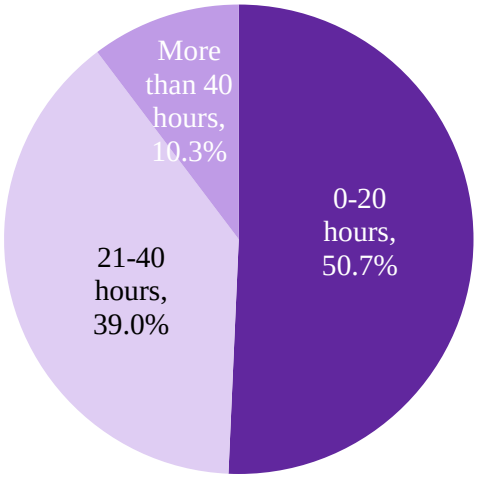


Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]

Number of jobs members have



Number of hours that members work each week



[27] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[28] Only reported the members who are over 18 years old.
[29] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

Exhibit 48. Members' living situation (n=5,590)

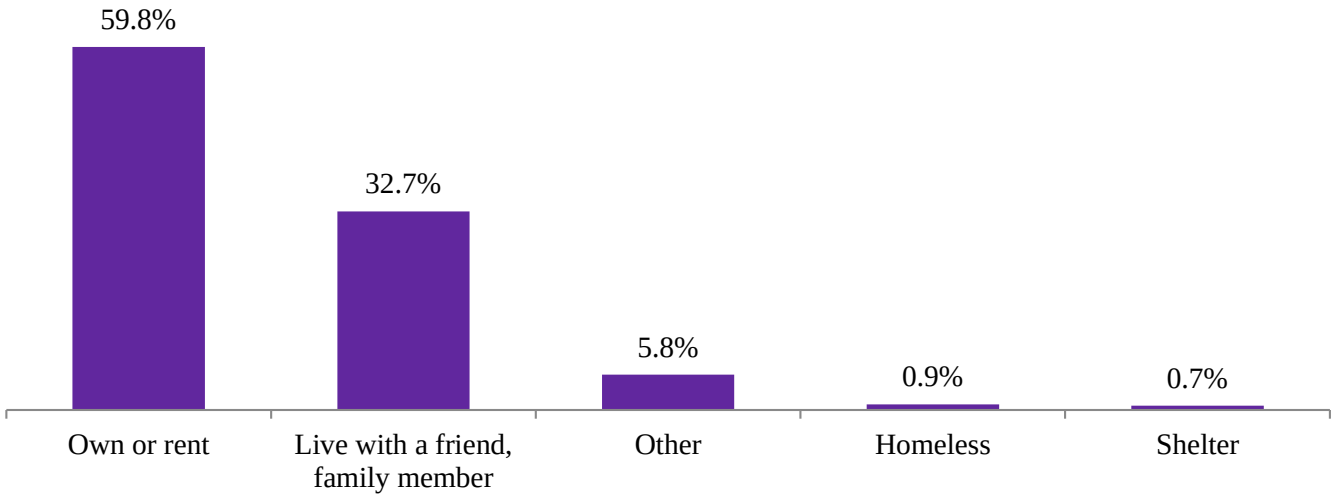
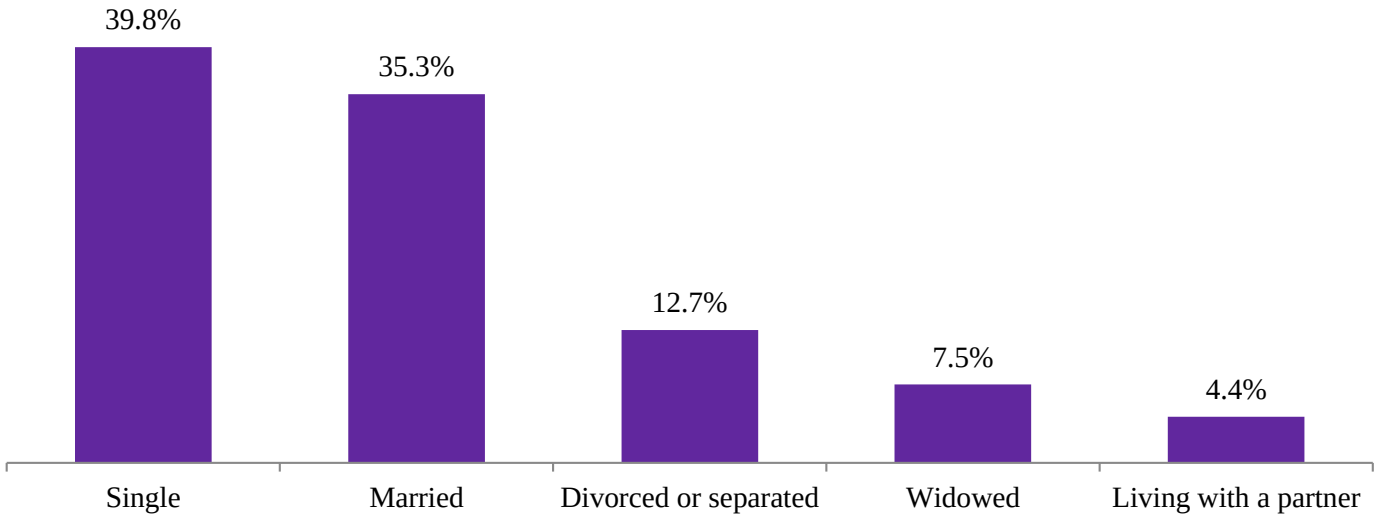


Exhibit 49. Marital status of members (n=3,271)[30]



[30] Only reported those who are over 18 years old.

Exhibit 50. Percent of members who were born in the United States (n=5,599)

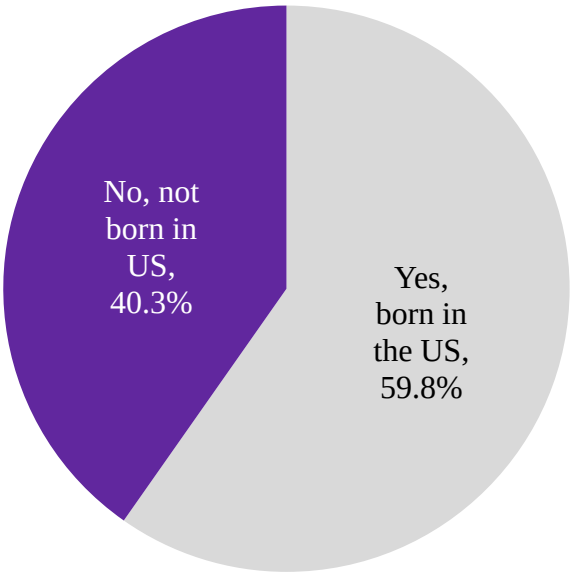
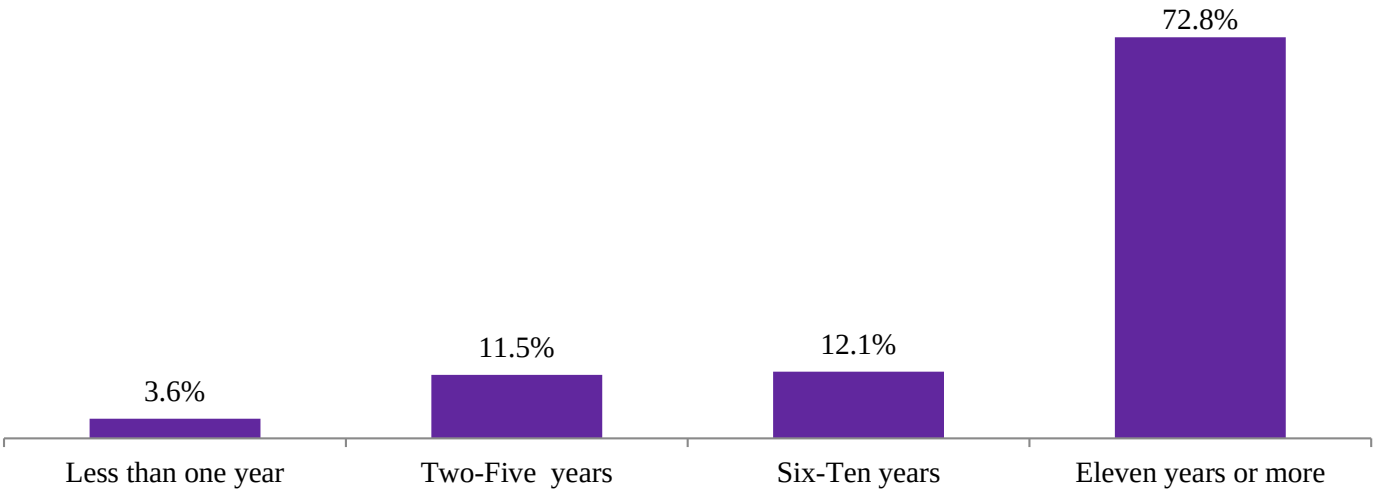


Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]



[31] Of those who were born outside of the U.S.

Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

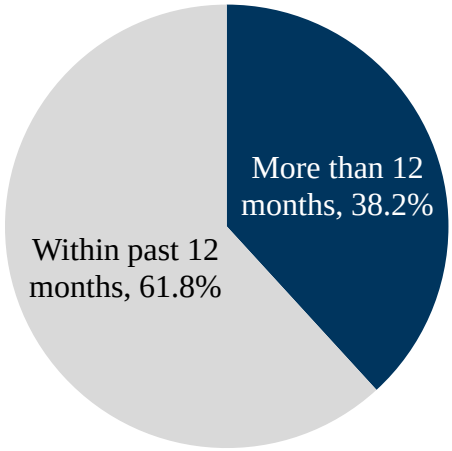
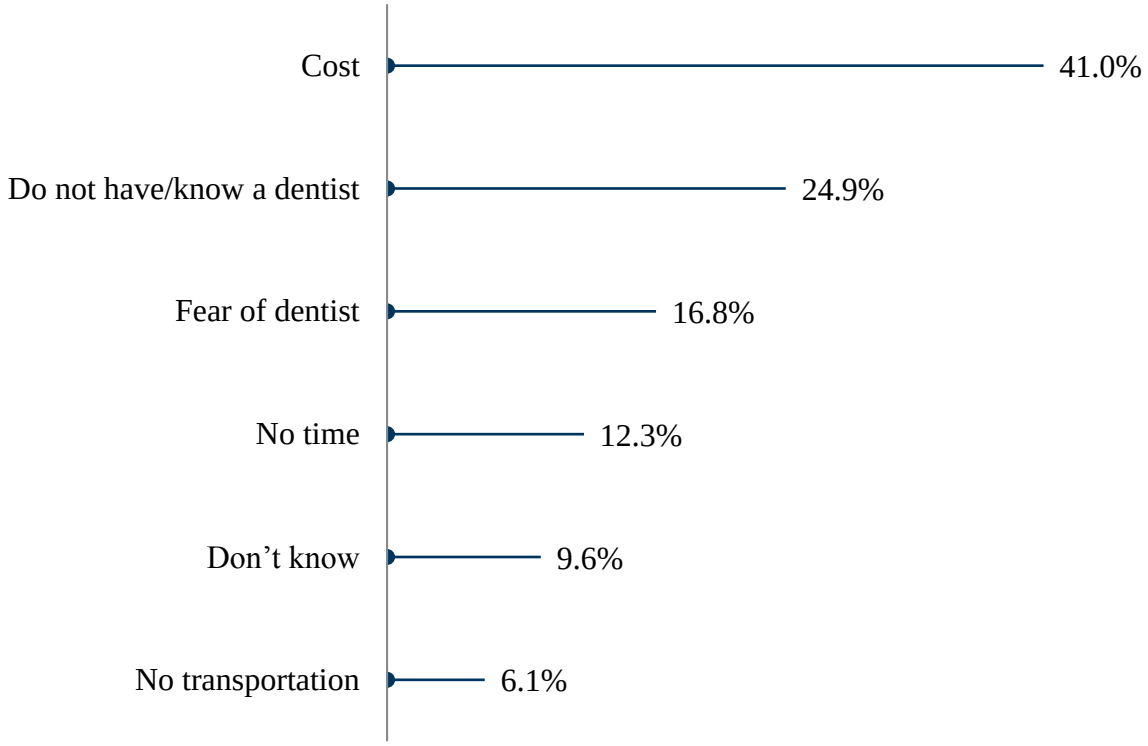
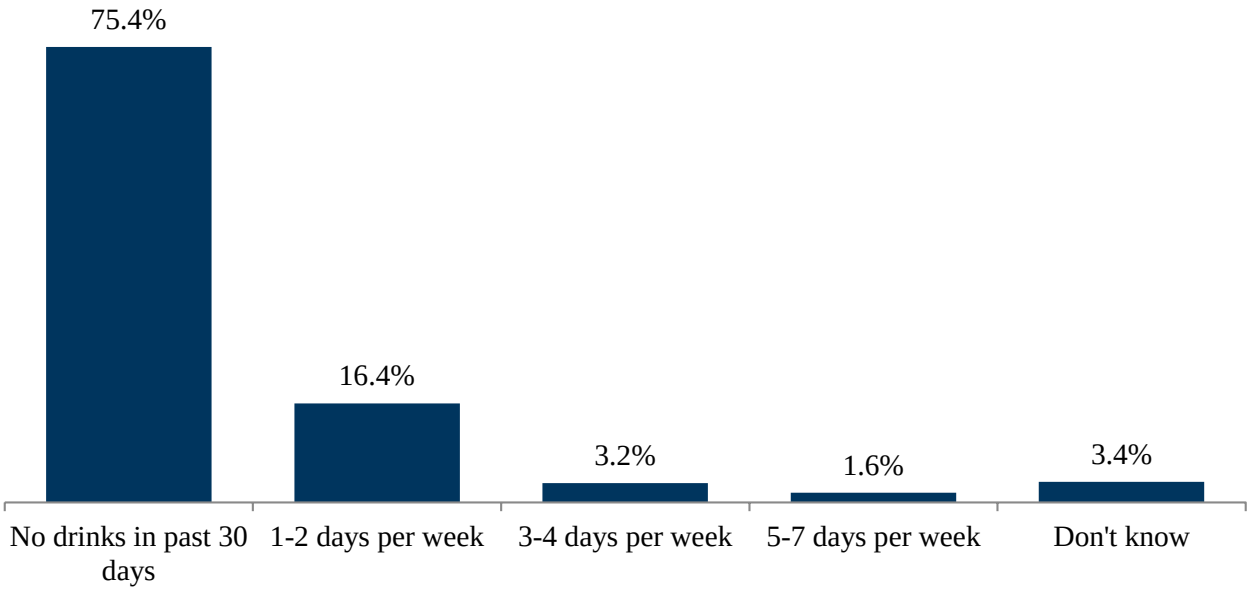


Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]



[32] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[33] Only reported those who have not seen a dentist within the past 12 months.

Exhibit 54. Days per week member had at least one drink of alcoholic beverage during the past 30 days (n=3,083)[34]



[34] Only reported those who are 18 years or older.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400
Cheryl Meronk, Director, Strategic Development (714) 246-8400

Recommended Action

1. Approve allocation of up to $11.4 million for Be Well Wellness Hub services to CalOptima Medi-Cal members from Board-approved Intergovernmental Transfer (IGT) 5 Adult and Children Mental Health priority area;
2. Authorize the CEO, with the assistance of Legal Counsel, to enter into a contract with the County of Orange Health Care Agency, or a three-way agreement with the Orange County Health Care Agency and Mind OC, including indemnification, defense and hold harmless provisions by the County of Orange and also by Mind OC (if three-way agreement), in an amount not to exceed $11.4 million, in exchange for at least five years of enhanced services provided to CalOptima Medi-Cal members at the Be Well Wellness Hub to commence once the Hub is operational.

Background

IGTs must meet state and federal requirements and must be approved by the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS).
Funding agreements provide that provider recipients will use their share of IGT-funded capitation rate increases for the provision of health care services to CalOptima Medi-Cal members. Similarly, where CalOptima retains portions of IGT-funded capitation increases, such funds are designated for health care services and administrative purposes that improve quality, access and efficiency in the Medi-Cal program for the benefit of CalOptima Medi-Cal members.

In December 2016, the CalOptima Board of Directors authorized an allocation of IGT 5 funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to award approximate $14.4 million in remaining IGT 5 funds. The funding categories included in DHCS-approved IGT 5 included:

- Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health; and
- Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver Initiatives. This would be one-time funding allocation for planning and to implement pilot programs as required.

At the February 2018 Board of Directors meeting, staff presented the Executive Summary of the MHNA as well as categories of needs in the community identified by the MHNA. The Board-approved categories included:

- Adult Mental Health
- Older Adult Mental Health
- Children's Mental Health
- Nutrition Education and Physical Activity
- Children's Dental Services
- Medi-Cal Benefits Education and Outreach
- Primary Care Access and Social Determinants of Health
- Adult Dental Services

Discussion

Be Well OC Regional Wellness Hub

The County of Orange and numerous other local public agencies, hospital systems, non-profit organizations, faith-based organizations and other community stakeholders have been meeting to discuss the mental health care system in Orange County. This group of stakeholders, known as the Orange County Coalition for Behavioral Health (the Coalition), now formally known as Be Well OC, came together to promote, facilitate and support existing mental health services and identify gaps in care that exist across the County. In addition, the Coalition formed a non-profit entity, Mind OC, to develop financial resources to support the goal of creating a high-quality behavioral health system of care.

While CalOptima Medi-Cal members are each assigned a primary care provider and a health network that are responsible for meeting member health care needs, results from the MHNA suggest that as many as 40% of CalOptima members may not know who to call or where to go for mental health services. In addition, Orange County hospital data indicates that more than 50% of Emergency Department (ED) visits for mental health and substance use disorder (SUD) issues involve Medi-Cal members[1]. The costs for these ED visits fall on CalOptima and its delegated health networks. The ED environment is often counter-indicated for the treatment of mental health and SUD. In certain situations, the ED may exacerbate the condition, potentially leading to longer stays and increasing the likelihood of an inpatient admission to a hospital-based psychiatric facility.

The Regional Wellness Hub (Hub), which is currently in its initial stages of development, will provide enhanced services for CalOptima's Medi-Cal members by integrating and co-locating CalOptima and County of Orange mental health and substance abuse services, and community-based social support services in a central, easily accessible location that improves access, addresses whole-person care, improves outcomes, and reduce recidivism. The goal is to redirect a meaningful percentage of mental health patients from the ED to the more appropriate care setting of a Regional Wellness Hub. Staff's understanding is that the County of Orange acquired 265 Anita Street in March of 2018 for the amount of $7.8 million and Be Well OC has provided additional financial resources to develop project plans and cost estimations.

Based on these factors, the CalOptima Board of Directors IGT 5 Ad Hoc Committee comprised of Supervisor Do and Director DiLuigi, recommends that CalOptima commit up to $11.4 million for the Be

[1] 2016 Office of Statewide Health Planning and Development (OSHPD)

Well OC Regional Wellness Hub, to be drawn from IGT 5 funds, consistent with DHCS-approved uses, to address the behavioral health needs of CalOptima members that are not carved out of CalOptima's State Contract.

Advance Funding Requirements

Operational details and services to be offered at the Hub have been developed including the go-live date, specific scope of mental health and other services; some other key considerations still need to be finalized. In addition, the volume of CalOptima members who will use the Hub is uncertain at this time and it is unknown how long it will take for services to meet the advance funding amount. As proposed, funds are being provided prior to commencement of services at the Hub, such that the County of Orange and Mind OC may end up using these funds for facility development, construction and/or other start-up costs, subject to the obligation to provide CalOptima Medi-Cal members services once the Hub is up and running. Given the uncertainty of these factors and CalOptima's advance funding, CalOptima will include indemnification, defense and hold harmless provisions to provide that the IGT 5 funds are returned if the Regional Wellness Hub project does not go forward, does not ultimately deliver mental health services that benefit CalOptima Medi-Cal members, or the use of the funds for the Hub by the County of Orange or Mind OC is challenged and/or recovered by any regulatory agency.

The up to $11.4 million advance funding for services to CalOptima Medi-Cal beneficiaries will be based on the following requirements:

- Services prepayment funding is contingent upon receiving written attestation that Mind OC has obtained the balance of funds required to complete construction of the first Wellness Hub, and that CalOptima's prepayment for services funding will be up to $11.4 million or one-third of the costs of development of the Wellness Hub, whichever is less;
- Commencement of development of the Wellness Hub by July 2020 and provision of agreed upon services to CalOptima Medi-Cal members no later than July 2021 based on Be Well's proposed construction schedule plus over an additional year for any potential delay;
- The Wellness Hub is to provide mental health and other related services to CalOptima Medi-Cal members at no additional cost to the members for the greater of five years or until the funding amount is exhausted (services provided to CalOptima Medi-Cal to be valued at the Medi-Cal Fee-for-Service equivalent cost for such services or other comparable agreed upon methodology). Service areas may include the following:
    - Triage
    - Psychiatric intake and referral
    - Substance use disorder intake and referral
    - Residential treatment services
    - An integrated support center providing community and faith-based services
- Services provided to CalOptima members (and charged to the CalOptima funding amount pursuant to this proposed arrangement) do not include mental health services (e.g., Specialty Mental Health Services) that are carved out of CalOptima's State Contract and are the financial responsibility of the County of Orange Health Care Agency (OCHCA) or Social Services Agency;
- The Wellness Hub must accept all CalOptima Medi-Cal members whose condition is appropriate for the facility; and

- The parties will agree upon specific services as part of a contract (between CalOptima, County of Orange, and Mind OC, as appropriate), ensuring OCHCA will oversee all Wellness Hub operations and services, and ensure CalOptima Medi-Cal members access to the agreed upon services. The contract must be approved by the CalOptima Board prior to funds being disbursed.

The Orange County Board of Supervisors and Be Well OC will finalize operational and program plans in early 2019. The CalOptima Board of Directors will be provided with an update at that time.

Fiscal Impact

The recommended action to approve a contract of up to $11.4 million from IGT 5 to the Orange County Health Care Agency, or the Orange County Health Care Agency and Mind OC in exchange for mental health services for CalOptima Medi-Cal members has no fiscal impact on CalOptima's operations budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Be Well OC Regional Wellness Hub
2. Be Well Orange County 265 Anita St. Proposal

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

Be Well OC Regional Wellness Hub

Board of Directors Meeting
December 6, 2018

Cheryl Meronk
Director, Strategic Development

Mental Health in Orange County

- CalOptima's Member Health Needs Assessment highlighted Mental Health as a priority need in the community
  - Providers identified mental/behavioral health as one of the most important health problems facing Medi-Cal beneficiaries
  - Lack of knowledge and fear of stigma are key barriers to receiving mental health services
    - Approximately 1 in 4 CalOptima members who needed mental health services did not see a mental health specialist
      - Members did not know who to call or how to ask for help
      - Members did not feel comfortable talking about personal problems

Be Well OC Regional Wellness Hub

- CalOptima is participating in Be Well OC, a collaborative initiative to make improvements to the mental health system of care in Orange County
- Be Well initiative includes creation of Regional Wellness Hubs
- Services available at the Wellness Hubs are expected to include (but may not be limited to):
  - Variety of mental health services
  - Substance Use Disorder treatment programs
  - Integrated support services linking community and social services
- Services available to any OC resident
  - Access based on clinical need

Wellness Hub Services May Include:

- Triage
- Psychiatric intake and referral
- Substance use disorder intake and referral
- Residential treatment services
- Integrated support services center
  - Mobile crisis response team
  - Transportation
  - Social and community-based services
  - Faith-based organizations
  - Education, employment and legal services

Be Well OC Regional Wellness Hub

- Benefits for CalOptima members
  - Centralized and accessible services
  - Whole person approach to address needs and coordination of care
  - Co-location of community-based social support services
  - Improved health outcomes and reduction in recidivism

- Estimates are that more than 50% of local Emergency Department visits for mental health and substance use disorder issues are CalOptima members

Anita St. Wellness Hub

- OCHCA 2016 Strategic Financial Plan includes a priority to develop an integrated behavioral health services campus
  - 44,600-square-foot building purchased at 265 Anita St. in Orange
- Planning for the facility evolved in parallel with Be Well OC Blueprint
  - 60,000-square-foot new construction planned in partnership with Be Well
- Initial project cost estimate: $34.2 million

Wellness Hub Funding Deliverables

- Up to $11.4 million funding contract for services to CalOptima members conditioned on the following:
  - Funding contingent upon receiving written attestation that Mind OC has obtained the balance of funds required to complete development of the first Wellness Hub
  - Construction of Wellness Hub to start no later than July 2020
  - Grand opening of Wellness Hub with full range of agreed upon services available to CalOptima members no later than July 2021
  - Wellness Hub must include agreed upon services at no cost to CalOptima or the member
  - Wellness Hub must accept all CalOptima members for first five years of operation until the funding amount is exhausted
    - Services provided to CalOptima Medi-Cal members to be valued at the Medi-Cal Fee-for-Service equivalent cost for such services or other comparable agreed-upon methodology
  - MindOC to enter into a three-way contract with OCHCA and CalOptima

Recommended Actions

- Approve allocation of up to $11.4 million for Be Well Wellness Hub services to CalOptima Medi-Cal members from Board-approved IGT 5 Adult and Children Mental Health priority area;
- Authorize a contract with County and Mind OC (including indemnity provisions) in an amount not to exceed $11.4 million, in exchange for at least five years of enhanced services for CalOptima Medi-Cal members at the Be Well Wellness Hub.



Be Well

ORANGE COUNTY

265 ANITA ST. PROPOSAL

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Vision: Be Well Orange County will lead the nation in optimal mental health[1] and wellness for all residents.



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[1]In the following document, the terms mental health and wellness encompass substance dependence and abuse.

A community in action.

Families across Orange County are suffering in the face of increasing mental health and substance use disorders. For many families, these challenges have become devastating catastrophes. If you are a resident of the Orange County community today, you undoubtedly have your own story – direct or indirect – to underscore this unfortunate reality.

265 Anita in the city of Orange is the first manifestation of Systems Change in Orange County. It is the place where we begin to build a new reality for this community, where together in public-private partnership we boldly impact individual, systemic and societal conditions so that all residents can Be Well.

265 Anita is a best-in-class regional treatment and wellness hub. It is a symbol of the strength and possibilities created when public and private partners strive together.

Orange County needs and deserves more than a new services building. **Let's build a beacon.**

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Executive Summary

Background

265 Anita St.

The Orange County HCA 2016 Strategic Financial Plan identified as a priority the creation of a campus-like setting for co-location of behavioral health services. In order to meet this need, HCA worked in collaboration with Orange County CEO/ Real Estate to purchase 265 Anita St. in the city of Orange. The 2.1 acre property hosts a 44,556 sq. ft. freestanding, two-story, stucco and glass office building with a landscaped, open-air atrium.

The HCA program planning process for the Anita St. building evolved in parallel with the public-private co-creation of the Be Well OC Blueprint (described in further detail in this section). Within that context, an opportunity emerged for a public-private partnership, between HCA and Mind OC (a not-for-profit organization described in further detail in this section), to design and develop a 60,000 sq. ft. building de novo, for the purpose of providing mental health and substance use disorder (SUD) services for all residents of Orange County regardless of payer.

Proposed here is the recommended plan to leverage public-private collaboration and actualize the full potential of 265 Anita St. as the county's first Be Well OC Regional Mental Health and Wellness Hub.



Opportunity

In Process

As the first Regional Wellness Hub, 265 Anita will be a trusted beacon for the Orange County community. To optimize this opportunity, HCA can leverage Mind OC's private sector expertise in real estate development and healthcare facility design to benefit from past learning and efficiencies in planning, project management and construction. Three primary advantages to this approach include:

- speed to market
- cost
- quality

With HCA's approval and collaboration, an exploration of this approach is underway. The contents of this proposal are the result of that work to date. The following pages include a target population assessment, program and services descriptions, design and construction options, financing recommendations, and additional operational considerations. Notably, the 265 Anita clinical program proposed here is comprised of multiple services identified to meet specific community needs as reflected in both county and hospital data. The clinical program and operational facility design have been co-created by the clinical leaders of the HCA and Mind OC.



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Executive Summary

Context

Be Well OC Blueprint

Co-created by a variety of public and private stakeholders across the county, a branded Be Well OC Blueprint clearly articulates the steps needed to actualize the Be Well OC vision. Success starts with acceptance that the mental health sector alone cannot solve this pervasive healthcare challenge. Neither can the public or private sectors sufficiently address the complexities alone. Be Well OC brings together a robust, community-based, cross-sector strategy – public, private, academic, faith and others – to positively impact those challenges that diminish mental health and well-being.

Be Well OC harnesses a best practice model known as Collective Impact, with a clearly defined leadership structure, to advance: education and prevention of mental illness, reduction of stigma, promotion of mental health, early identification of problems, and comprehensive, coordinated treatment. Be Well OC will establish a community-wide, coordinated ecosystem of optimal mental health support and services.

Mind OC

Mind OC is a community-owned, not-for-profit, 501(c)3 created to support the advancement of Be Well OC and the Orange County mental health and wellness ecosystem. The Mind OC governance board is comprised of a cross-sector, multidisciplinary team of Orange County leaders. The team sets goals, develops strategy and deploys plans through focused work streams and specialized project workgroups, managing the cross-functional alignment of these efforts. Accountabilities include oversight and management of work streams and projects, ensuring adequate information, resources and support are provided, and serving as liaison to key stakeholders. Mind OC has three primary areas of focus:

1. Mental health and wellness infrastructure development

2. Value optimization and transparency in mental health and SUD services

3. Be Well OC sustainability and public/private partnerships

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Regional Hubs

As a foundational component of the Blueprint, and essential to effective services coordination, three regional anchoring Wellness Hubs are required to support the Be Well mental health system of care. The Wellness Hubs will include a variety of mental health and SUD treatment programs and are uniquely available to all residents of Orange County, regardless of payer. Access is based on clinical need.

The Wellness Hubs will be intentionally located and designed in synergistic compliment with the Homeless System of Care, and the goals of each respective Service Planning Area (SPA). It is critical to note the three Wellness Hubs are not designed exclusively to serve the OC homeless population. Hubs will have sufficient service and staffing capacity to address a range of mental health and wellness levels of risk and complexity. Each Hub will also integrate support services providing necessary linkage with myriad complimentary community and social services.





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Community Need

OC Emergency Department Volume, 2016 OSHPD

DIAGNOSES	Total OC Market	5 Mile Radius of 265 Anita	% of Total
Alcohol-related disorders	10,645	2,773	26.1%
Substance-related disorders	6,388	1,984	31.1%
Mood disorders	5,695	1,890	33.2%
Suicide and intentional self-inflicted injury	4,498	1,306	29.0%
Schizophrenia and other psychotic disorders	4,067	1,477	36.3%
Delirium dementia and amnestic and other cognitive disorders	960	285	29.7%
Miscellaneous mental health disorders	888	322	36.3%
Attention-deficit conduct and disruptive behavior disorders	484	174	35.9%
Screening and history of mental health and substance abuse codes	252	66	26.4%
Personality disorders	105	41	39.0%
Totals:	**34,024**	**10,336**	**30.4%**

Payer Mix	5 Mile Radius Payer Mix %	Total OC Market	5 Mile Radius of 265 Anita
Medi-Cal	52.9%	15,441	5,463
Commericial	23.0%	10,772	2,379
Self Pay	11.4%	3,823	1,176
Medicare	11.3%	3,464	1,172
Other	1.4%	525	147
Totals:	**100.0%**	**34,024**	**10,336**

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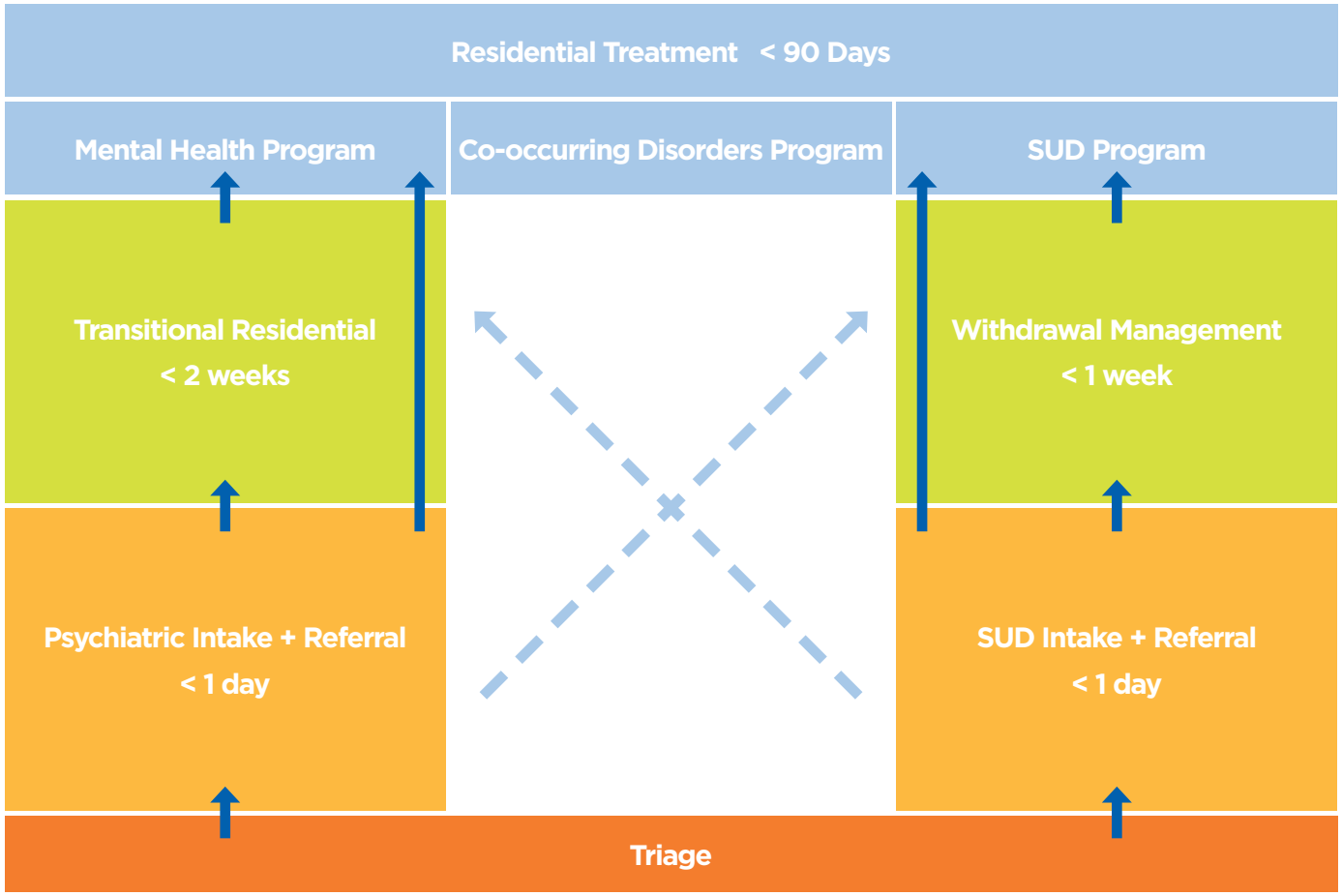
Proposed Program

The sum is greater than the parts. Integration of mental health and substance abuse services in a central, easily accessible location improves access. Coordination in care and operational synergy among services improves experience for patients and providers. Co-locating community-based social support services honors whole-person needs and a whole-systems approach, improves outcomes and reduces recidivism.



Integrated Support Services:

- Mobile Crisis Response Teams
- Transportation
- Social Services Support
- Community Based Organizations
- Faith Based Organizations
- Supportive Employment
- Supportive Education
- Legal Aid Services

*See Appendix for Program Access Projections and Discharge Planning.

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Proposed Services

There are seven different service elements that make-up the program at this first Be Well Regional Hub. OCHCA will hold the contracts with the various organizations providing the clinical services. The contracted providers will be required to contract with commercial health plans to ensure access to all members of the community regardless of the payer. Revenue from commercial health plans to the service provider will be applied to the cost reimbursement funds they are paid, lowering HCA's cost burden.

Program	Description	Length of Stay
Triage	**Target population:** Adults and adolescents are separated in this receiving area for walk-in/drop-offs to the campus. Screening is completed to determine clinical fit for the onsite programs. If onsite services are not appropriate for the need, a referral and transportation are provided.	**N/A**
Psychiatric Intake + Referral	**Target population:** Walk-in/drop off services for adults and adolescents with acute behavioral health challenges, who are at risk of hospitalization and present on a voluntary or involuntary basis. Services include: basic medical and medication services, psychiatric and psychosocial evaluation, crisis intervention, therapeutic support, education, and linkage to the clinically indicated level of continuing care.	**< 1 day**
Substance Use Disorder (SUD) Intake/Referral	**Target Population:** Walk-in/drop-off services for adults under the influence of drugs and alcohol. Services include: voluntary screening, assessment, physical safety and monitoring, and linkage to the clinically indicated level of continuing care.	**< 1 day**
Withdrawal Management	**Target Population:** Individuals who can safely withdrawal from alcohol and/or other drugs in a safe and supportive community/residential environment. Services include: counseling, withdrawal monitoring and support.	**< 1 week**
Transitional Residential	**Target Population:** Adults in psychiatric decline requiring longer term stabilization to ensure safe transition. Services include: on-going assessment, psychiatric medication management, individual and group intervention, substance abuse education and treatment, and family and significant-other involvement.	**< 2 weeks**
Residential Treatment	**Target Population:** Persons living with Serious Mental Illness and co-occurring SUD. Specialized residential treatment services include: assessment, individual and group counseling, monitoring psychiatric medications, substance abuse education and treatment, and family and significant-other involvement.	**< 90 days**
Integrated Support Center	Through the expansion of the existing footprint of the building, additional services have been identified that function synergistically in support of the above programs. These include: • Mobile Crisis Response Team • Transportation • Social Services • Community Based Organizations • Faith Based Organizations • Supportive Employment • Supportive Education • Legal Aid Services	**N/A**

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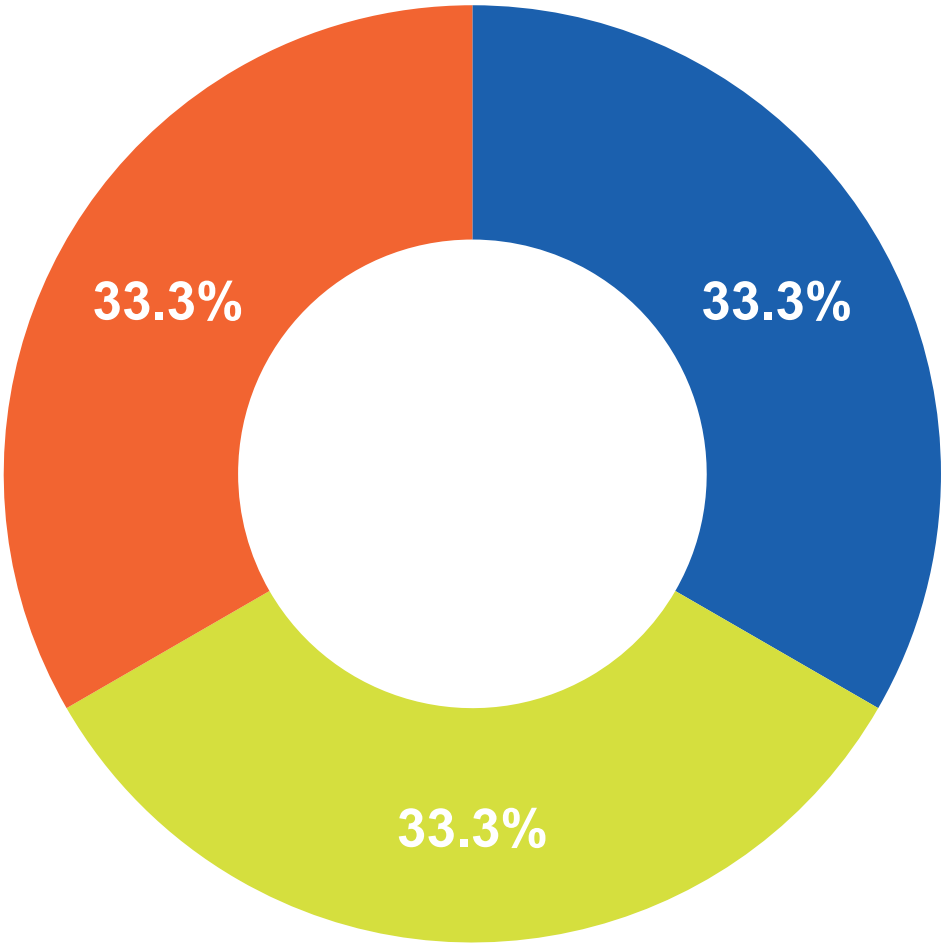
Financing Model

Syndicated Prorata Share



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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Cheryl Meronk, Director, Strategic Development, (714) 246-8400

Recommended Actions

1. Authorize the release of Requests for Proposal (RFPs) for community grants with staff returning at a future Board meeting with recommendations for award decisions; and
2. Authorize the reallocation of IGT 2 funds remaining from the Autism Screening project to Community Grants consistent with the state-approved IGT 2 approved funding categories.

Background

In December 2016, the CalOptima Board of Directors authorized an allocation of IGT 5 funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to address the unmet needs identified by the MHNA.

At the February 2018 Board of Directors meeting, staff presented the Executive Summary of the MHNA as well as categories of needs in the community identified by the MHNA. The Board-approved categories included:

- Adult Mental Health
- Older Adult Mental Health
- Children's Mental Health
- Nutrition Education and Physical Activity
- Children's Dental Services
- Medi-Cal Benefits Education and Outreach
- Primary Care Access and Social Determinants of Health
- Adult Dental Services

After the June 7, 2018 Board of Directors meeting, CalOptima released a notice for Requests for Information (RFI) from organizations to better define the scopes of work to address community needs in one or more of the above referenced categories. CalOptima received a total of 93 RFI responses from community-based organizations, hospitals, county agencies and other community interests. The 93 RFI responses are listed as follows:

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MHNA Categories	# of RFIs
Adult Mental Health	15
Older Adult Mental Health	13
Children's Mental Health	13
Nutrition Education and Physical Activity	12
Children's Dental Services	5
Medi-Cal Benefits Education and Outreach	10
Primary Care Access and Social Determinants of Health	19
Adult Dental Services	6
TOTAL	93

Subject matter experts and grant administrative staff performed an examination of all the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

The Ad Hoc Committee, comprised of Supervisor Do and Director DiLuigi, met on November 9, 2018 to discuss the results of the 93 RFI responses for the MHNA categories and review the staff-recommended RFPs for consideration.

Following the review of the RFI responses, the staff evaluation process and recommendations, the Ad Hoc committee recommended moving forward with the following Community Grant categories:

Community Grant Requests for Proposal (RFPs)

Grant RFP	Total Grant Award
1. Access to Children's Dental Services	$1,000,000
2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	$1,400,000
3. Access to Adult Dental Services	$1,000,000
TOTAL	**$3,400,000**

Staff is also recommending the reallocation of an amount up to $400,000 remaining from the IGT 2 Autism Screening Project to support these community grants. This provider incentive project aimed at increasing the access to autism screenings for CalOptima children members has been discontinued. The program was able to screen a total of 110 children. Support of the grant RFPs fulfills the original Board-approved uses of the IGT 2 funds which were as follows:

1. Enhance CalOptima's core data analysis and exchange systems and management information technology infrastructure to facilitate improved coordination of care for Medi-Cal members;
2. Continue and/or expand on services and initiatives developed with 2010-11 IGT funds;
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health integration, preventive dental services and supplies, and incentives to encourage members to participate in initial health assessment and preventive health programs.

Funding for the above grant RFPs is derived as follows:

- **$3.0 million**: Remaining from IGT 5 (following anticipated Board action related to other IGT 5 funds)
- **$0.4 million:** Reallocation from IGT 2 Autism Screening Project
- **$3.4 million:** Total available for distribution through Community Grants

Following receipt and review of the RFP responses, evaluation committees consisting of staff and other subject matter experts will evaluate the responses based on a standardized scoring matrix, and will return to the Board with recommendations and proposed funding allocations.

Fiscal Impact

Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations. The recommended action to authorize the release of the Requests for Proposal (RFPs) for community grants has no additional fiscal impact to CalOptima.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence

Gary Crockett, Chief Counsel

Attachment

PowerPoint Presentation: Community Grant RFP Recommendations

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

11/28/2018 — **Date**

CalOptima
A Public Agency
Better. Together.

Community Grant RFP Recommendations

Board of Directors Meeting
December 6, 2018

Cheryl Meronk
Director, Strategic Development

IGT 5 Process Summary to Date

Board authorizes Member Health Needs Assessment (MHNA) to guide expenditure of IGT5 funds

MHNA identifies categories for community grants

Board authorizes Requests for Information (RFIs) to better define the scopes of work in each of the categories

93 RFI responses lead to the identification possible Requests for Proposal (RFPs)

Board Ad Hoc committee meets to consider recommending that the full Board authorize RFPs

IGT 5 Expenditure Process

- Subject matter experts and grant administrative staff evaluated/scored all 93 RFI responses by category
  - Evaluation committees met July 30–August 9
  - Provided recommendations on scopes of work to be developed into RFPs

- Ad Hoc Committee reviewed all 93 RFI responses
  - Recommended grant to Be Well OC for first Wellness Hub
  - 3 RFPs proposed

Grant Funding

- **$14.4M** CalOptima's share of IGT 5
- **-$11.4M** Recommended grant to Be Well OC for first Wellness Hub
- **$ 3.0M** Remaining for recommended distribution for Community Grants
- **$ 400K** Re-allocation from IGT 2 Autism Screening Project
- **$ 3.4M** **Total Available for Community Grants**

Three Recommended Grant RFPs

RFP #	RFP Description	Funding Amount
1	Access to Children's Dental Services	$1 million
2	Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	$1.4 million
3	Adult Dental Services	$1 million
	Total	**$3.4 million**

* Multiple awardees may be selected per RFP

RFP 1

Access to Children's Dental Services and Outreach

- **Funding Amount:** $1 million
- **Description:**
  - Provide mobile dental outreach at schools with preventative, restorative treatment/services as well as outreach and education for examinations, screenings, resources, etc.
  - Assist children/families with establishing a dental home close to their home for emergency and regular dental care
  - Provide or partner with other community dental providers to ensure patients receive restorative and other specialty dental services in addition to exams and screenings as needed

RFP 2

Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)

- **Funding Amount:** $1.4 million
- **Description:**
  - Establish and/or operate school-based wellness centers where family, staff and community partners collaborate to align resources
  - Partner with health clinics that allow for school referrals and follow-up care
  - Provide health assessment/screenings on school campuses and community-based education for families

RFP 3

Adult Dental Services and Outreach

- **Funding Amount:** $1 million
- **Description:**
  - Expand availability of dental services/treatment at health centers and/or mobile units with medical care integration for comprehensive health care
  - Ensure provider/staff capacity to perform assessment and restorative dental services
  - Expand dental services to nontraditional evening and weekend hours
  - Establish collaboration with community clinics/resources for specialized dental care

Next Steps*

Mid-December 2018: CalOptima releases Community Grant RFPs, if approved

January 2019: RFP responses due

March 2019: Ad Hoc reviews recommended grant awards

April 2019: Board considers approval of grant awards

April 2019: grant agreements executed

* Dates are subject to change based on Board approval

RFP 1. Access to Children's Dental Service				
Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
AltaMed Health Services Corporation	$ 156,064	Expansion of Portable Oral Health Services and Tele-dentistry in Orange County	Expand access to portable Oral Health Unit services through addition of a Dental Hygienist and introduce a tele-dentistry component into the program.	600
Coalition of Orange County Community Health Centers	$ 1,000,000	Mouths Matter: Establishing a Dental Home for All Children	Provide a dental home with a mobile dental unit equipped to provide pediatric preventive and restorative treatment, thereby completing the circle of dental care. This project will enable five federally qualified health centers (FQHC) and FQHC Look-Alikes to establish a dental home with regular and emergency care for children and families	9,000
Healthy Smiles for Kids of Orange County	$ 1,000,000	Full Cycle Dentistry	Provide preventive (screenings, dental cleanings, fluoride, sealants) and restorative treatment (fillings and cavity treatment) to CalOptima children at schools, primary care clinics, and community sites. Children who require advanced restorative treatment (such as treatment under general anesthesia) will be referred to traditional clinics in Garden Grove and CHOC Children's Hospital.	13,564
Kha Dang Le Dental Corporation	$ 1,000,000	Community Dental Care Access for Children	Educate members on optimal dental health by creating a strong traditional and social media presence. Provide exams and screenings to students in a mobile dental vehicle.	1,000

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Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Vista Community Clinic	$ 251,432	Development of a Mobile Dental Care Program for Children in North Orange County	Develop a mobile dental care program in conjunction with the school districts and schools to do full dental exams, take x-rays, place sealants, and address problems such as dental caries.	1,310

RFP 2. Primary Care Services & Social Determinats of Health

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
CHOC Children's	$ 1,396,813	The School-based Student Wellness Center: Addressing the Social Determinants of Health Where Children Are	Create three School-based Student Wellness Centers within three Orange County school districts and enhance current mental health OC Department of Education (OCDE) offerings with novel physical health and social determinant services led by a school site Coordinator and staffed by medical, nutrition, fitness, and social services personnel.	3,886
Coalition of Orange County Community Health Centers	$ 1,400,000	Healthy Kids, Healthy Schools	Collaborate with five schools in establishing school-based wellness centers throughout Orange County. These wellness centers will provide immunizations, health screenings, health education, and direct comprehensive health care (medical, dental, vision, and behavioral health) with community clinics. Six letters of support from schools/school districts were submitted.	5,500

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Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
NAMI Orange County	$ 174,794	Decreasing Stigma Through Mental Health Education, While Increasing Access to Wellness Resources	NAMI-OC will host Ending the Silence (ETS) presentations and conduct outreach at schools to further educate and increase awareness surrounding mental health conditions. Resource Navigation services will also be offered for students and their families.	13,590
Santa Ana Unified School District	$ 1,400,000	Family and Community Engagement (FACE) Wellness Centers	Enhance the Family and Community Engagement (FACE) Wellness Centers at all 57 K-12 school sites across the school district. Service providers, healthcare professionals, and local clinics will conduct services within the centers which are located within walking distance from the homes of families and residents of the entire Santa Ana community. SAUSD collaborates with local stakeholders; business organizations, institutions of higher learning, for-profit and nonprofit organizations in order to provide wrap-around services for students, families and the surrounding community. Several agreements have already been established with service providers to partner with the SAUSD.	50,000

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Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Serving Kids Hope	$ 1,351,412	School-Based Wellness Program	The project formalizes district-wide wellness assessment based on State Wellness Standards, establishing baseline and measurement of impact. It will be data-driven, with district-wide wellness assessment, documented services, and analysis and reporting of outcomes. Two letters of support from school districts were submitted.	25,975
Wellness & Prevention Center	$ 224,631	Expansion and Integration of South Orange County School-Based Wellness Centers into the CalOptima Primary Care Network	Expand five school-based wellness centers and leverage existing agreement with the Capistrano United School District. Project will increase bilingual staff, expand parental engagement, and create educational materials.	300
RFP 3. Access to Adult Dental Service				
Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
AltaMed Health Services Corporation	$ 150,678	Expanded Access to Adult Dental Services in Orange County	Expand access through the addition of a dental team in the Santa Ana clinic location and expand service hours (evening and weekend). The project also: increases awareness about coverage; promotes timely treatment plan completion; links members to a dental home; and integrates culturally-responsive, language-appropriate dental and medical services.	300

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Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Camino Health Center	$ 50,000	Adult Dental Services Expansion	Camino Health Center will be using funds to provide additional evening and weekend hours in the current dental clinic. The additional hours will allow more patients in the community access to receive dental services with hours that may be more compatible to their personal schedules. The additional funding for elective dental procedures with lab fees will allow patients to have access to procedures not covered by insurances.	150
Families Together of Orange County	$ 1,000,000	Bridging the Gap: Addressing Orange County's Oral Health Needs	Open a new health center with four dental exam rooms located on the border of Garden Grove and Anaheim, targeting patients who speak Arabic, Spanish, or Vietnamese. Dental care will be integrated into FTOC's comprehensive primary care services with evening and weekend hours.	6,000
KCS Health Center (Korean Community Services)	$ 987,600	Integration of MECCA Community Based Organizations with FQHC Adult Oral Care Access in Mobile and Nontraditional Delivery Modalities	KCS Health Center requests to build mobile sites at each of its six (6) partnering MECCA community-based organizations and extend hours of operation to nontraditional hours at the mobile sites as well as at KCS Health Center and Southland Integrated Services locations. The organizations together serve populations that speak Spanish, Vietnamese, Korean, Farsi, Arabic, and Khmer	8,000

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Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Kha Dang Le Dental Corporation	$ 1,000,000	Community Dental Care Access for Adults	Educate members on optimal dental health by creating a strong traditional and social media presence. Add an additional day (on Fridays) for 9 hours to provide more access to care and allow more appointments.	1,000
Livingstone Community Development Corporation	$ 350,000	Finding Your Smile: Expanding Dental Services for Adults Beyond Emergency Care	Expand direct preventive and restorative dental services by increasing dental program staff, extending hours and days of operation and providing improved integration with its primary care program. The dental program will provide exams and x-rays, dental cleaning, cavity fillings, extractions, root canal treatments, and crowns.	2,500
Serve the People	$ 1,000,000	Oral Health for the Homeless	Establish dental care access points with a three-chair dental mobile unit at 10 homeless shelters managed by homeless support service providers. These new dental homes will provide preventative, restorative, and specialized dental care to CalOptima members.	1,500
St. Jeanne de Lestonnac Free Clinic	$ 180,000	Oral Health Program	Increase outreach efforts and purchase equipment and supplies to treat more patients. Dental services include exams, x-rays, fillings, root canals, and tooth extractions. Lab work and/or dental prosthetics will be available to patients at cost with no additional markup.	100

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Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Vista Community Clinic	$ 251,432	Development of a Mobile Dental Care Program for Adults in North Orange County	Develop a mobile dental care program serving adults in La Habra to do full dental exams, x-rays, sealants, and addressing problems such as dental caries. The program will be include an outreach initiative, to helping to raise awareness of safety-net healthcare services, and promoting knowledge of and access to CalOptima's health care services.	1,426

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Allocation of Intergovernmental Transfer (IGT) 5 Funds Towards a Community Grant(s) for Access to Children's Dental Services

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions

1. Award IGT 5 funds in the amount of up to ~~$1 million~~ $500,000 to Coalition of Orange County Community Health Centers and up to $500,000 to Healthy Smiles for Kids of Orange County ~~for a~~ for community ~~grant(s)~~ grants for Access to Children's Dental Services; and
2. Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant ~~contract(s)~~ contracts with the selected community ~~grantee(s)~~ grantees.

Rev. 10/3/19

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At its April 7, 2016 meeting, the CalOptima Board of Directors approved priority areas for IGT 5 to guide CalOptima's community support, including the priority area "Strengthening the Safety Net." To gain greater awareness of the unique healthcare needs of CalOptima members, the Board authorized staff to contract with a vendor to conduct a Member Health Needs Assessment in December 2016. The health needs assessment was completed in February 2018, and in June 2018, the Board authorized release of eight Requests for Information (RFI) to help inform development of scopes of work for Requests for Proposals (RFP) under IGT 5, including an RFP related to Children's Dental Services. In July 2018, 93 RFI responses were received. At its December 6, 2018 meeting, the Board approved a prepayment of $11.4 million for services to be provided to CalOptima members at the Be Well Wellness Hub, and the release of three RFPs, including one involving up to $1 million to support Access to Children's Dental Services within the Strengthening the Safety Net priority area.

Five responses to the Access to Children's Dental Services RFP were received, and an external subject matter expert and staff evaluated and scored the responses. These results were shared with the IGT 5 Board Ad Hoc Committee comprised of Vice Chair Khatibi and Director Nguyen. On July 23, 2019, this Ad Hoc Committee met to consider the RFP responses. Following the review of the evaluation results and the site visit comments, the Ad Hoc Committee recommended that $1 million be awarded to Healthy Smiles for Kids of Orange County. On August 1, 2019, the Board considered the Ad Hoc Committee's recommendation and deferred action, directing staff to return to the full Board with additional information. The item was then agendized and subsequently continued from the agenda for the September 5, 2019 Board meeting.

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Discussion

During the August 1, 2019 meeting, the Board directed staff to provide additional information on the RFP development and evaluation process, as well as the findings of the evaluation and final scores of the proposals submitted in response to the Access to Children's Dental Services RFP.

RFP Development

The Access to Children's Dental Services Scope of Work (attached) was based on responses to the RFIs received in July 2018 and required applicants to address the following topics in their proposals:

- Provide mobile dental outreach at schools with preventative, restorative treatment/services as well as outreach and education for examinations, screenings, resources, etc.;
- Assist children/families with establishing a dental home close to their home for emergency and regular dental care;
- Provide or partner with other community dental providers to ensure patients receive restorative services in addition to exams and screenings as needed; and,
- Include integration with medical care for early childhood through referral for well-check visits.

RFP Evaluation Process

The RFP evaluations were based on an Evaluation Matrix (attached) including the weighted categories below:

- Organization Information (10%)
- Project Information (55%)
  - Statement of Need (5%)
  - Project Description (20%)
  - Evidence Supporting Approach (5%)
  - Outreach and Education (10%)
  - Sustainability Plan (5%)
  - Population Served (10%)
- Project Staffing (10%)
- Project Budget (10%)
- Work Plan information (15%)

Listed below are the two highest rated RFP responders along with their scores based on evaluation of their respective written RFP responses.

	Evaluation Criteria										
	Organization	Statement	Description	Evidence	Outreach	Sustainability	Population	Staffing	Budget	Workplan	Grand Total
Coalition of Orange County Community Health Centers											
Score	15	15	15	14	15	14	14	13	15	15	145
Weight	10%	5%	20%	5%	10%	5%	10%	10%	10%	15%	100%
Total Score	1.5	0.75	3	0.7	1.5	0.7	1.4	1.3	1.5	2.25	4.87
Healthy Smiles for Kids of Orange County											
Score	14	15	14	13	13	11	15	15	14	14	138
Weight	10%	5%	20%	5%	10%	5%	10%	10%	10%	15%	100%
Total Score	1.4	0.75	2.8	0.65	1.3	0.55	1.5	1.5	1.4	2.1	4.65

Some highlights from their applications are summarized below.

	Coalition of Orange County Community Health Centers (Coalition)	Healthy Smiles for Kids of Orange County (Healthy Smiles)
Title	Mouths Matter: Establishing a Dental Home for All Children	Full Cycle Dentistry
Requested Amount	$1 million	$1 million
Score	4.87	4.65
Description	• Will establish a new mobile unit to be shared by five community health clinics ○ Families Together of Orange County, Korean Community Services, North Orange County Regional Health Foundation, Serve the People, and Southland Integrated Services • Adds a new provider for dental services, as one of these clinics does not provide dental services	• Enhances four mobile units and a mini clinic to ramp-up restorative care (e.g., staff, equipment, supplies, outreach and engagement materials) • Will increase access to preventive and restorative care • Have provided dental services to children in Orange County through clinics and school-based programs since 2003 • Expects to collaborate with 11 school districts

	○ The other four clinics provide pediatric dental services at their fixed sites • Expects to collaborate with six school districts	
Use of Funds (examples)	• Purchase and equipping mobile unit • Consulting (coordinating with clinics for HRSA change in scope/licensing and curriculum development) • Staff • Supplies (e.g., dental, oral hygiene kits)	• Restorative and portable equipment expansion • Recruitment and training for 20 new clinical positions, as well as portion (less than 20%) salary and other costs • Service fees (contract reviews and move costs for mini clinic) • Supplies for mobile units, mini clinic, staff, outreach materials
Term and Population Served	• During the three-year term: Will serve additional 9,000 CalOptima members ○ First year focusing on infrastructure development (e.g., acquisition of three chair mobile unit, staffing, etc. ○ Services delivery begins in Year 2	• During the one-year term: Will serve 13,500 additional CalOptima members ○ Impact begins immediately upon funding with service delivery begins within three-months

After the evaluations of the written RFP responses were scored and discussed by the RFP review team, site visits were conducted by staff with the top two scoring RFP responders. During the site visits, the applicants had the opportunity to respond to additional questions and share further details on their submitted proposals. Areas for discussion include the following:

- The RFP responding organization's understanding of the project and impact, as well as consistency to its mission and fit with current services provided;
- The RFP responder's leadership capacity and skills to effectively provide the proposed services and address foreseeable challenges;
- Whether services may be duplicative or complementary of those provided by others and opportunities for collaboration; and,
- Any other concerns with, or benefits of awarding, a grant to the organization.

Following the site visit with the Coalition of Orange County Community Clinics, it was noted that the collaborating clinics are very passionate about their work; in addition to the required build out of the mobile unit itself, one of the clinics did not have a dental practice within its fixed site to leverage and, thus, would have to establish a dental practice. Additionally, the grant program implementation was not

entirely clear. Following the site visit with Healthy Smiles for Kids of Orange County, it was noted that the grant would augment an existing program within an established organizational structure; the presentation demonstrated that project goals and objectives were well understood. RFP responses were not rescored after the site visits.

Request for Proposal Evaluation Process – Ad Hoc Review

The IGT 5 Board Ad Hoc discussed the two highest scoring written proposals: Coalition of Orange County Community Health Centers and Healthy Smiles for Kids of Orange County, and considered information from the written proposals, scoring results and site visits. Both organizations submitted strong proposals, with the Coalition being more focused on acquisition of a mobile unit, services and outreach, and Healthy Smiles being more focused on enhancing the current delivery system by ramping up of mobile restorative services e.g., through acquisition of restorative equipment, portable equipment and supplies, and recruitment of new clinicians.

Information considered by the Ad Hoc Committee included whether the respective proposed approaches would expand an established program or add a new program, ramp-up time for services to start and completion time, access and outreach through school districts and other community partners, and new members expected to be served during and beyond the term of the grant.

The Ad Hoc Committee also considered options to split the grant award. At the Ad Hoc's direction, Staff reached out to the two organizations with the highest scoring applications to obtain their feedback related to use of funds if 100% of their proposed grant funding amounts were not awarded, and if they were instead offered 75%, 50%, or 25% of their proposed funding levels. Based on feedback from these two applicants, splitting the amount did not appear to be a viable option. Subsequently, based on the Board's direction, staff again reached out to the applicants following the August 1, 2019 Board meeting to ask them to confirm their ability to accept a smaller grant award amount. Each applicant expressed scalability:

- *Coalition of Orange County Community Clinics*: Two clinics participating in the collaborative have recently acquired additional funding commitment to support purchase and equipping two three-chair mobile clinics. As a result, the initial proposed funding amount could be significantly reduced, ramp up time would be reduced to five months, with the Coalition still achieving the deliverables included in its RFP response (e.g., number of schools engaged, outreach conducted, members served).

- *Healthy Smiles for Kids of Orange County:* In the event the award amount is reduced, the number of children served would be reduced proportionately, for example, 50% award, half of the 13,500 children would be served, while otherwise meeting all deliverables. Services would begin immediately upon receipt of grant funding.

Previous Awards
Below is information about prior IGT awards to the two highest scoring RFP responders:

- *Coalition of Orange County Community Clinics*: Prior to IGT 6/7, had not previously received a grant. The Board awarded $6,000,000 for Medication Assisted Treatment under IGT 6/7 to the Coalition on August 1, 2019; contracting is in progress and the funds have not yet been released.

- *Healthy Smiles for Kids of Orange County*: Previously received a grant under IGT 2 for $400,000 in June 2015 to use two mobile units (one then recently acquired) to expand school-based dental service from 36 to 50 schools including dental screenings, education and preventive care. Activities included developing proposals and enlisting support of school principals and nurses to attain school district approval, developing proposals for school boards, identifying target schools, educating school principals, nurses, teachers and parents, professional and administrative staff, and supplies for a recently acquired mobile unit. The final report on this grant reflecting the objectives, activities, evaluation indicators and timeline was submitted on June 20, 2017 reflecting that by the end of the first year, 56 new sites had been added (some lower volume schools were removed from the program). Total screenings and sealants per year prior to the grant term were 8-10,000 and 3,000 respectively; during the two-year grant term, nearly 30,000 students were screened and more than 31,000 sealants applied.

Fiscal Impact
The recommended action to award up to $1 million in grant funding from IGT 5 funds has no fiscal impact to CalOptima's operating budget because IGT 5 funds are accounted for separately. Expenditure of IGT 5 funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision of working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, continues to work with our provider and community partners to address the health needs of Orange County Medi-Cal beneficiaries, filling in gaps and working to improve the availability, access and quality of health care services CalOptima members receive.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Covered Entities
2. PowerPoint Presentation: IGT 5 Community Grant Award Consideration: Children's Dental.
3. Scope of Work IGT 5 RFP 1 Children's Dental
4. Evaluation Matrix
5. CalOptima Board Action dated June 7, 2018, Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)
6. CalOptima Board Action dated December 6, 2018, Consider Authorizing Release of Requests for Proposal (RFPs) for Community Grants to Address Categories from the Intergovernmental Transfer (IGT) 5 Funded CalOptima Member Health Needs Assessment and Authorizing Reallocation of IGT 2 Funds
7. CalOptima Board Action dated August 1, 2019, Consider Allocation of Intergovernmental Transfer (IGT) 5 Funds Towards Community Grants
8. Healthy Smiles for Kids of Orange County Final Report dated June 30, 2017 with referenced spreadsheet
9. IGT 5 Community Grant Application Summary Ad Hoc Top 2 Proposals

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Attachment 1 to October 3, 2019 Board of Directors Meeting – Agenda Item 12

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
Coalition of Orange County Community Health Centers	515 N. Cabrillo Park Dr. Ste. 225	Santa Ana	CA	92701
Healthy Smiles for Kids of Orange County	10602 Chapman Ave., Ste. 200	Garden Grove	CA	92840
	2010 E. Fourth Street, Ste. A220	Santa Ana	CA	92705
Kha Dang Le Dental Corporation	2121 East Coast Hwy, # 220	Corona Del Mar	CA	92625
	146 S Main St Ste M	Orange	CA	92868
	9900 McFadden Ave, Ste 101	Westminster	CA	92683
Vista Community Clinic	1000 Vale Terrace Drive	Vista	CA	92084
	201 S Harbor Blvd	La Habra	CA	90631

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IGT 5 Community Grant Award Consideration: Children's Dental Services

Board of Directors Meeting

October 3, 2019

Candice Gomez

Executive Director, Program Implementation

IGT 5 Background

- April 2016: Board approved five priority areas
- December 2016: Authorized Member Health Needs Assessment
  - February 2018: Assessment completed
- June 2018: Released Requests for Information (RFI)
  - July 2018: Received 93 RFI responses
- December 2018: Board approved $11.4 million for Be Well Wellness Hub and the release of three RFPs
  - Access to Children's Dental Services, Primary Care Services and Programs Addressing Social Determinants of Health, and Access to Adult Dental Services
- February 2019: Received 20 RFP responses
- August 2019: Awarded grants for Primary Care Services and Programs Addressing Social Determinants of Health, and Access to Adult Dental Services, and deferred the grant for Access to Children's Dental Services

Children's Dental Services: Scope of Work

- Provide mobile dental outreach at schools with preventative, restorative treatment/services as well as outreach and education for examinations, screenings, resources, etc.
- Assist children/families with establishing a dental home close to their home for emergency and regular dental care
- Provide or partner with other community dental providers to ensure patients receive restorative services in addition to exams and screenings as needed
- Include integration with medical care for early childhood through referral for well-check visits

RFP Evaluation Process: Scoring

- Review RFP proposals based on set criteria
  - Organization Information (10%)
  - Project Information (55%)
    - Statement of Need (5%)
    - Project Description (20%)
    - Evidence Supporting Approach (5%)
    - Outreach and Education (10%)
    - Sustainability Plan (5%)
    - Population Served (10%)
  - Project Staffing (10%)
  - Project Budget (10%)
  - Work Plan Information (15%)

RFP Evaluation Process: Site Visit

- Purpose of a site visit is to augment the quantitative evaluation of written proposals with qualitative information
  - Better understand the organization and its current programs
  - Learn more about the proposed project and how it fits with the organization's mission
  - Identify the organization's leadership capacity and skills to effectively provide the proposed services
- Site visits conducted with top two applicants
- Observations from site visits included in staff report

Proposal Descriptions

- Coalition of Orange County Community Health Centers (COCCC)
  - Establish a new mobile unit to serve five community health centers
    - Families Together of Orange County, Korean Community Services, North Orange County Regional Health Foundation, Serve the People and Southland Integrated Services
  - Support a new provider of dental services
    - Four of the five centers currently have dental clinics, and this proposal will support the fifth so all can provide preventive and restorative services
- Healthy Smiles for Kids of Orange County (Healthy Smiles)
  - Enhance four mobile units and a mini clinic to ramp up restorative care (e.g., staff, equipment, supplies, outreach and engagement)
  - Increase access to preventive and restorative care

Top Applicants' Evaluation Scores

	Evaluation Criteria										
	Organization	Statement	Description	Evidence	Outreach	Sustainability	Population	Staffing	Budget	Workplan	Grand Total
Coalition of Orange County Community Health Centers											
Score	15	15	15	14	15	14	14	13	15	15	145
Weight	10%	5%	20%	5%	10%	5%	10%	10%	10%	15%	100%
Total Score	1.5	0.75	3	0.7	1.5	0.7	1.4	1.3	1.5	2.25	4.87
Healthy Smiles for Kids of Orange County											
Score	14	15	14	13	13	11	15	15	14	14	138
Weight	10%	5%	20%	5%	10%	5%	10%	10%	10%	15%	100%
Total Score	1.4	0.75	2.8	0.65	1.3	0.55	1.5	1.5	1.4	2.1	4.65

Key Considerations

- Ramp-up time for service delivery
  - COCCC: One year of capacity building
  - Healthy Smiles: Immediate expansion of current program
- Number of children served during grant term
  - COCCC: 9,000 children via 6 school districts and other partners
  - Healthy Smiles: 13,500 children via 11 school districts and other partners
- Sustainability plan
  - COCCC: Services are sustainable through reimbursement since all participating health centers are FQHCs or FQHC Look-Alikes
  - Healthy Smiles: Advocate for support from government agencies and local grant programs; and advocate for reimbursement/ increased coverage for vulnerable populations through Denti-Cal

August Board Meeting Follow-Up

- Board directed staff to follow up with finalists regarding a potential adjustment of the grant amounts
  - COCCC: Organization shared new information since the August Board meeting. Coalition received funding commitment from another source for two mobile dental units, reducing in funding needs and ramp up time to five months. With $500,000 in IGT 5 funding, Coalition would serve all 9,000 children and meet all deliverables
  - Healthy Smiles: Organization responded that the proposal is scalable. A reduced award would result in a proportionate reduction in children served (e.g., 50% award, half of 13,500 children served) while otherwise meeting all deliverables

Recommended Board Actions

1. Award IGT 5 funds in the amount of up to $1 million for a community grant(s) for Access to Children's Dental Services; and
2. Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contract(s) with the selected community grantee(s)

CalOptima's Mission

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

SCOPE OF WORK

IGT 5 Children's Health: Expand Access to Children's Dental Services and Provide Outreach

I. OBJECTIVE

In 2017, CalOptima conducted one of the most extensive and inclusive Member Health Needs Assessment (MHNA) in its 20-plus year history. The results provided critical data to ensure CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. Having the data means CalOptima and the community can make more informed decisions about where to focus improvements.

The MHNA highlighted some key findings that included social determinants of health, mental health, primary care access, provider access and dental care. Overall considerations included:

- Members are culturally diverse and want providers who both speak their language and understand their culture;
- Lack of knowledge and fear of stigma are key barriers to utilizing mental health services;
- Most member are connected to primary care but unsure about what oral health services are covered by CalOptima;
- Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

To help decrease the number/percentage of children who have not seen a dentist within the past 12 months as indicated in CalOptima's Member Health Needs Assessment (MHNA), CalOptima's Board of Directors allocated funds for community grants to support local organizations with expanding access to children's dental services and provide outreach.

Grant funds must be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of grant funds, thus funding is best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

CalOptima is awarding $1 million for children's dental services program(s) that 1) includes partnership/collaboration with other organizations to increase the number of CalOptima members served, 2) provides outreach and education as part of their program to promote awareness, and 3) has the ability to be self-sustainable after grant funds have been exhausted.

II. SCOPE OF WORK BASICS

1) PRODUCTS/SERVICES

a) Provide mobile dental outreach at schools with preventative, restorative treatment/services as well as outreach and education for examinations, screenings, resources, etc.
b) Assist children/families with establishing a dental home close to their home for emergency and regular dental care
c) Provide or partner with other community dental providers to ensure patients receive restorative services in addition to exams and screenings as needed.
d) Include integration with medical care for early childhood through referral for well-check visits

2) SUPPLIER'S RESPONSIBILITIES

(a) Provide a workplan with SMART (specific, measurable, achievable, realistic and time-bound) goals, objectives and major activities.
(b) Perform the specific measure objectives/outcomes and submit tracking towards the results.
(c) Create and demonstrate an outreach and education plan for promoting and connecting proposed services to CalOptima members.
(d) Identify, track and report how many additional CalOptima members will be served.
(e) Identify, track and report how staffing will be allocated to the program/project.
(f) Provide services and activities in a culturally competent and relevant manner.

3) CALOPTIMA'S RESPONSIBILITIES

CalOptima will provide the following templates:
(a) Progress, Annual and Final Report templates;
(b) Project Budget form;
(c) Staffing Plan form;
(d) Coordination and scheduling periodic site visit with grantees.

4) DELIVERABLES

Submit and participate in the following to CalOptima:

(a) **Quarterly Progress Reports**, submitted via CalOptima's grant management system, will be due within thirty (30) calendar days after the end of each project quarter.
(b) **Annual Progress Report**, submitted via CalOptima's grant management system, will be due within thirty (30) calendar days after the end of the first year of this Grant Contract.
(c) **Final Report**, submitted via CalOptima's grant management system, will be due within. thirty (30) calendar days after the end of this Grant Contract. The template for this report is also provided through CalOptima's grant management system.

(d) Payment(s) are contingent upon the receipt and acceptance of timely reports and positive progress in identified goals and objectives**.**
(e) Participate in a pre-scheduled site visit(s) with grantee at location of project services.

5) PERFORMANCE MEASURES

(a) CalOptima actively monitors and evaluates grant progress and requires submission of progress reports with demonstrated positive progress in achieving the identified goals and objectives.
(b) CalOptima may perform additional site visits to evaluate performance.

2019 RFP SCORING MATRIX

Section	Criteria	Excellent		Good		Poor
		5	4	3	2	1
A. Organization Information (10%)	Organizational Capacity/Financial Condition/Completeness of Application: -Board/Advisory Members Roster -IRS Determination Letter (if applicable) -Form 990 (if applicable) -Most Recent Audited Financial Statements -Completed IRS W-9 Form -Project Staffing Plan -Project Budget Plan	Organization is in excellent financial standing with high liquidity and minimal risk of insolvency (e.g., revenue is higher than expenses, no debt, healthy cash savings, etc.); demonstrates an excellent track record of service to the community and has the capacity to effectively provide proposed services; all requested items included with application. Board/Advisory Members roster is complete and highly organized/robust.		Organization is in good financial standing with minimal liquidity and moderate risk of insolvency (e.g., revenue is slightly higher than expenses, low debt, satisfactory cash savings, etc.); demonstrates a good track record of service to the community and has the capacity to adequately provide proposed services; some or all requested items included with application. Board/Advisory Members roster is satisfactory.		Organization is in poor financial standing with little to no liquidity and high risk of insolvency (e.g., expenses are higher than revenue, high debt, insufficient cash savings, etc.); demonstrates a poor track record of service to the community and lacks the capacity to effectively provide proposed services; some or none of the requested items included with application. Board/Advisory Members roster is incomplete and not organized/robust.
B. Project Information (55%)	Statement of Need (5%)	Provides a clear and realistic explanation of the issue and need(s) in the community; need(s) identified is supported by local statistics and data.		Provides a basic explanation of the issue and need(s) in the community; need(s) identified is supported by non-local statistics and data.		Provides a poor explanation of the issue and need(s) in the community; need(s) identified are not supported by any statistics or data.
	Project Description (20%)	Provides clear and insightful project information; detailed and sensible plan on how goals and outcomes will be achieved. Proposed project has significant potential to address the identified unmet need in the community. Seeks very appropriate collaborations to increase the effectiveness of proposed project.		Provides basic project information; adequate plan on how goals and outcomes will be achieved. Proposed project has minor potential to address the identified unmet need in the community. Seeks basic collaborations to increase the effectiveness of proposed project.		Provides unclear and poor project information; poor plan on how goals and outcomes will be achieved. Proposed project has little to no potential to address the identified unmet need in the community. Seeks little to no collaborations to increase the effectiveness of proposed project.
	Evidence Supporting Approach (5%)	Provides clear and relevant evidence regarding promising practices to support the efficacy of the proposed project.		Provides some generalized evidence regarding promising practices to support the efficacy of the proposed project.		Provides unclear and irrelevant evidence regarding promising practices to support the efficacy of the proposed project.

2019 RFP SCORING MATRIX

Section	Criteria	Excellent		Good		Poor
		5	4	3	2	1
B. Project Information (55%)	Outreach and Education Strategy (10%)	Provides clear and specific information on how applicant will promote and connect CalOptima members to proposed services; clear and detailed description on how applicant will specifically track the number of CalOptima members reached.		Provides basic information on how applicant will promote and connect CalOptima members to proposed services; adequate description on how applicant will specifically track the number of CalOptima members reached.		Provides insufficient and unclear information on how applicant will promote and connect CalOptima members to proposed services; poor and unclear description on how applicant will specifically track the number of CalOptima members reached.
	Sustainability Plan (5%)	Provides clear and specific information on how the project will be sustained after grant support has ended; plan is very compelling and feasible.		Provides basic information on how the project will be sustained after grant support has ended; plan is adequate and slightly feasible.		Provides poor information on how the project will be sustained after grant support has ended; plan is not compelling and feasible.
	Population Served (10%)	The number of additional CalOptima members served is relatively high and is greater than or equal to 25% of CalOptima members currently served; demonstrates a strong awareness of the demographics and diverse needs throughout Orange County.		The number of additional CalOptima members served is less than 25% of CalOptima members currently served; demonstrates an adequate awareness of the demographics and diverse needs throughout Orange County.		The number of additional CalOptima members served is relatively low and is less than 10% of CalOptima members currently served; demonstrates a poor awareness of the demographics and diverse needs throughout Orange County.
C. Project Staffing Plan (10%)	Project Staffing Plan	Provides a complete staffing plan that is appropriate and reasonable for the proposed project. Provides a clear and detailed explanation on how applicant will identify, track, and report how staffing will be allocated to the project/program.		Provides a basic staffing plan that lacks detail for the proposed project. Provides a basic explanation on how applicant will identify, track, and report how staffing will be allocated to the project/program.		Provides a poor staffing plan that is not appropriate and realistic for the proposed project. Provides a poor explanation on how applicant will identify, track, and report how staffing will be allocated to the project/program.
D. Project Budget Plan (10%)	Project Budget Plan	Provides a complete budget plan that is appropriate and realistic for the proposed project and timeframe; indirect costs do not exceed the 10% limit.		Provides a basic budget plan that lacks detail for the proposed project and timeframe; indirect costs do not exceed the 10% limit.		Provides a budget plan that is not appropriate and realistic for the proposed project and timeframe; indirect costs exceed the 10% limit.
E. Workplan Information (15%)	Workplan Information	Provides a detailed workplan for implementation that is appropriate to the goals and length of the project; activities for objectives are clear and realistic; demonstrates a high likelihood of achieving objectives.		Provides a basic workplan for implementation that is moderately appropriate to the goals and length of the project; activities for objectives are satisfactory; demonstrates an adequate likelihood of achieving objectives.		Provides a poor workplan that is not appropriate to the goals and length of the project; activities for objectives are weak; demonstrates a low likelihood of achieving objectives.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

41. Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

Authorize the release of Requests for Information (RFI) for the eight board-approved categories identified by the CalOptima Member Health Needs Assessment to develop specific Scopes of Work for full Requests for Proposal (RFP).

Background

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to award approximate $14.4 million in IGT 5 funds.

CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders.

At the February 1, 2018 Board of Directors meeting, staff presented the results and Executive Summary of the MHNA as well as requested authority to release Requests for Proposal (RFP) for community grants. From the information gathered, the MHNA identified eight board-approved categories as needs in the community. The eight board-approved categories include:

1. Expand Access to Mental Health Services for Adults
2. Expand Access to Mental Health and Socialization Services for Older Adults
3. Expand Access to Mental Health/Developmental Services for Children Ages 0-5
4. Expand Access to Nutrition Education and Fitness Programs for Children and their Families
5. Increase Medi-Cal Benefits Education and Outreach
6. Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health
7. Expand Access to Adult Dental Services
8. Expand Access to Children's Dental Services

Approval to release the RFPs was unanimous by the Board of Directors.

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Discussion
In preparation for the release of the community grant RFPs, staff conducted a review of the descriptions for each of the eight categories identified by the MHNA. Staff recognized a need to narrow and better define a more precise and definitive Scope of Work (SOW) for each category. The specific SOWs for the RFPs will be developed based on the responses received from the RFI process. The RFI responses will be evaluated to select innovative ideas for services and programs to address the needs of CalOptima members. Staff will review the RFI responses and develop full RFPs so that interested community-based organizations, public agencies and other eligible entities can submit a proposal for consideration. More than one idea per category may be selected from the RFI responses and developed into a full RFP.

Staff is requesting authority to release RFIs for the eight board-approved categories that were identified through the MHNA. Staff will return to the Board for approval of the scopes of work developed in conjunction with the RFI and to release the RFPs.

Fiscal Impact
There is no fiscal impact to CalOptima's general operating budget.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima staff plans to work with our provider and community partners to address gaps in health care services for CalOptima members.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Board Action dated February 1, 2018, Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

Member Health Needs Assessment

Board of Directors Meeting
February 1, 2018

Cheryl Meronk
Director, Strategic Development

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Member Health Needs Assessment

A better study offering deeper insight, leading to a healthier future.

A Better Study

- ➔ More Comprehensive
- ➔ More Engaging
- ➔ More Personal

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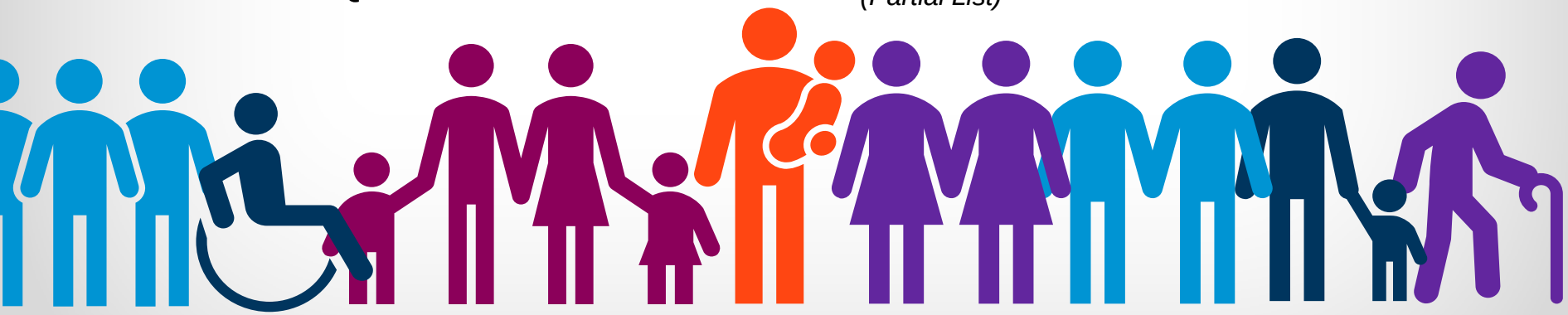
More Comprehensive

- Reached new groups of members whose voices have rarely been heard before
  - Young adults with autism
  - People with disabilities
  - Homeless families with children
  - High school students
  - Working parents
  - New and expectant mothers
  - LGBTQ teens
  - Homeless people in recuperative care
  - Farsi-speaking members of a faith-based group
  - PACE participants
  - Chinese-speaking parents of children with disabilities

(Partial List)



More Comprehensive (Cont.)

- Gathered responses from all geographic areas of Orange County



More Comprehensive (Cont.)

- Probed a broader view of members' lives beyond immediate health care needs
  - Hunger
  - Child care
  - Economic stress
  - Housing status
  - Employment status
  - Physical activity
  - Community engagement
  - Family relationships
  - Mental health
  - Personal safety
  - Domestic violence
  - Alcohol and drug consumption

(Partial List)

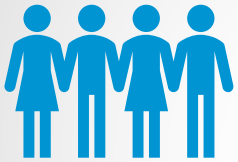


More Comprehensive (Cont.)

- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In the past 12 months, did you have the need to see a mental health specialist?
  - How open are you with your doctor about your sexual orientation?
  - How sensitive are your health care providers in understanding your disability?

(Partial List)

More Engaging: Members



Focus Groups

- 31 face-to-face meetings in the community
- 353 members



Telephone Conversations

- 534 live interviews in members' languages



Mailed Surveys

- Nearly 6,000 surveys returned



Electronic Responses

- More than 250 replied conveniently online

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More Engaging: Member Advocates

- Abrazar Inc.
- Access CA Services
- Alzheimer's OC
- Boys & Girls Club
- The Cambodian Family
- CHOC
- Dayle McIntosh
- La Habra Family Resource Center
- Latino Health Access
- Korean Community Services
- Mercy House
- MOMS Orange County
- OMID
- SeniorServ
- South County Outreach
- State Council on Developmental Disabilities
- Vietnamese Community of OC Inc.

(*Partial List)*

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More Personal

- Met in familiar, comfortable locations at convenient times for our members
  - Apartment complexes
  - Churches
  - Community centers
  - Schools
  - Homeless shelters
  - Recuperative care facilities
  - PACE center
  - Community clinics
  - Restaurant meeting rooms



More Personal (Cont.)

- We spoke their language
  - English
  - Spanish
  - Vietnamese
  - Korean
  - Farsi
  - Chinese
  - Arabic
  - Cambodian
  - Marshallese
  - American Sign Language



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Offering Deeper Insight

- ➔ Barriers to Care
- ➔ Lack of Awareness About Benefits and Resources
- ➔ Negative Social and Environmental Impacts

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Notable Barriers to Care

- Study revealed that members encounter structural and personal barriers to care
  - Structural
    - It can be challenging to get an appointment to see a doctor
    - It takes too long to get an appointment
    - Doctors do not always speak members' languages
    - Interpreter services are not always readily available
    - Doctors lack understanding of members' cultures
  - Personal
    - Members don't think it is necessary to see the doctor
    - Members have personal beliefs that limit treatment
    - Members are concerned about their immigration status
    - Members are concerned someone would find out they sought mental health care

Barriers to Care (Cont.)

Examples

52%

Don’t think it is necessary to see the doctor for a checkup

28%

Takes too long to get an appointment

26%

Concerned someone would find out about mental health needs

41%

Didn’t think it is necessary to see a specialist, even when referred

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Notable Lack of Awareness

- Survey revealed a lack of understanding about available benefits and services
  - 25 percent of members who needed to see a mental health specialist did not pursue treatment
  - 38 percent of members had not seen a dentist in more than a year

- Focus group participants commented frequently about having difficulty regarding certain resources
  - Interpreter services
  - Social services needs
  - Transportation

Lack of Awareness (Cont.)

Examples

40%

Didn’t know who to ask for help with mental health needs

41%

Didn’t see a dentist because of cost (i.e., didn’t know dental care was covered)

25%

Don’t have or know of a dentist

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Negative Social and Environmental Impacts

- Survey revealed significant social and environmental difficulties
  - Lack of well paying jobs and employment opportunities
  - Lack of affordable housing
  - Social isolation due to cultural differences, language barriers or fear of violence
  - Economic insecurity and financial stress
  - Lack of walkable neighborhoods and the high cost of gym programs

Negative Impacts (Cont.)

Examples

32%
Needed help getting food in the past six months

56%
Accessing other public assistance

43%
Needed help to buy basic necessities

29%
Needed help getting transportation

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Negative Impacts (Cont.)

Stakeholder Perspective

> There's a significant issue with improper nutrition. They may not have enough money or the ability to go to the grocery store to buy the right foods. They get what they can, and that's what they eat.
>
> *—Interviewee*

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Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

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Funding

$14.4 Million

Total Available IGT 5 Funds

- **Member Health Needs Assessment results drive funding allocations**

- **Eight Requests for Proposal (RFPs) to expand access to mental health, dental and other care, and outreach/education services**

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RFP 1

Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $5 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category

Adult Mental Health

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RFP 2

Expand Mental Health and Socialization Services for Older Adults

Funding Amount: $500,000

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category

Adult Mental Health

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RFP 3

Expand Access to Mental Health/ Developmental Services for Children 0–5 Years

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Shortage of pediatric mental health professionals
- ✓ Shortage of children's inpatient mental health beds
- ✓ Increase in adolescent depression

Funding Category

Children's Mental Health

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RFP 4

Nutrition Education and Fitness Programs for Children and Their Families

Funding Amount: $1 million

Findings Addressed

- ✓ Healthier food choices can be more expensive, less convenient and less accessible
- ✓ Cultural foods may not be the healthiest options
- ✓ Lack of time and safe places may limit physical activity

Funding Category
Childhood Obesity

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RFP 5

Medi-Cal Benefits Education and Outreach

Funding Amount: $500,000

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits

Funding Category

Supporting the Safety Net

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RFP 6

Expanded Access to Primary Care and Programs Addressing Social Determinants of Health

Funding Amount: $4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Lack of ability to cover basic necessities

Funding Category

Supporting the Safety Net

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RFP 7

Expand Adult Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1.4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Limited dental providers for adults

Funding Category

Supporting the Safety Net

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RFP 8

Expand Access to Children's Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not utilizing covered services
- ✓ Challenging to get an appointment to see a provider

Funding Category

Children's Health

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Moving Forward

- Eight Grant Applications/RFPs
  - Expand access to mental health, dental and other care services
  - Expand access to childhood obesity services regarding nutrition and fitness
  - Support outreach and education regarding social services and covered benefits
- RFPs to be released in March 2018
- Recommended grantees to be presented at June Board meeting

EXECUTIVE SUMMARY
MEMBER HEALTH NEEDS ASSESSMENT

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In summer and fall 2017, more than 6,000 CalOptima members, service providers and community representatives participated in one of the most extensive and inclusive member health needs assessments (MHNA) undertaken by CalOptima in its 20-plus year history. The MHNA provides data critical to ensuring that CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima participates in numerous efforts to assess the health of Orange County's residents and create community-driven plans for improving the health of the Medi-Cal population. Some examples are detailed below.

- The 2013 Orange County Health Profile, produced by the Orange County Health Care Agency, highlighted key health indicators as well as other social, economic and environmental indicators that impact health conditions in groups of people based on economics, race, ethnicity, gender, age and geography.
- The 2016 Orange County Community Indicators Report tracked and analyzed Orange County's health and prosperity on a myriad of issues.
- The 2017 Conditions of Children in Orange County Report offered a comprehensive and detailed summary of how children in Orange County fair in the areas of health, economic well-being, educational achievement, and safe homes and communities.
- CalOptima's Group Needs Assessment, conducted every five years with annual updates in between, identifies members' needs, available health education, cultural and linguistic programs, and gaps in services.

When combined, these assessments provide a broad picture of important health information in Orange County. However, they do not focus specifically on Medi-Cal beneficiaries or on ethnic and linguistic minorities within this population, whose health needs are at the core of CalOptima's mission. For this reason, CalOptima undertook this comprehensive MHNA, summarized on the following pages.

By the Numbers

5,815
Surveys

31
Focus Groups

24
Stakeholder Interviews

21
Provider Surveys

10
Languages

Birth–101
Years of Age

CalOptima's comprehensive MHNA is an innovative collaboration that builds upon existing data-gathering efforts and takes them a step further. The study was designed to be a more comprehensive assessment, using engaging methods that resulted in a much more personal experience for our members and the community. The MHNA captures the unique and specific needs of Medi-Cal beneficiaries from an array of perspectives, including providers, community leaders and, most importantly, the members themselves. As a result, this in-depth study offers actionable recommendations for consideration by the CalOptima Board of Directors and executive leadership.

The MHNA was designed to help CalOptima identify:

1. Unique needs and challenges of specific ethnic communities, including economic, social and environmental stressors, to improve health outcomes

2. Challenges to health care access and how to collaborate with community-based organizations and providers to address these barriers

3. Member awareness of CalOptima services and resources, and effective strategies to increase awareness as well as disseminate information within target populations

4. Ways to leverage outreach efforts by partnering with community-based organizations on strategic programs

Our Partners

To guide the direction of the study, CalOptima established an MHNA Advisory Committee made up of community-based representatives. The committee then engaged CalOptima staff and Harder+Company Community Research (Harder+Company), in partnership with the Social Science Research Center (SSRC) at California State University, Fullerton. A summary of their qualifications to participate in this extensive effort is below.

Harder+Company was founded in 1986 and works with philanthropic, nonprofit and public-sector clients nationwide to reveal new insights about the nature and impact of clients' work. Harder+Company has a deep commitment to lifting the voices of marginalized and underserved communities — and working across sectors to promote lasting change. In addition, Harder+Company offers extensive experience working with health organizations to plan, evaluate and improve services for vulnerable populations, along with deep experience assisting hospitals, health departments and other health agencies on a variety of efforts, including conducting needs assessments, engaging and gathering meaningful input from community members, and using data for program development and implementation.

SSRC was established in 1987 to provide research services to community organizations and research support to university faculty. The center's primary goal is to assist nonprofit and tax-supported agencies and organizations to answer research questions that will lead to improved service delivery and public policy. The SSRC conducts surveys, evaluation research and other applied research activities to meet its clients' information needs. The center conducts multilingual telephone surveys from its 24-station computer-assisted telephone interviewing lab, as well as web-based, mailed and face-to-face surveys. In the past 10 years, SSRC has successfully completed 200 telephone survey projects using a variety of sample designs in diverse areas of focus, such as health care, public safety, education, workforce development and pregnancy prevention.

harder + co | community research

CALIFORNIA STATE UNIVERSITY FULLERTON

Due to strong partnerships with the community, the 2017 MHNA engaged members who may be hard to reach. We are proud that our efforts included:

- Young adults on the autism spectrum
- People with disabilities
- Homeless families and children
- High school students
- Working parents
- New and expectant mothers
- LGBTQ teens
- Farsi-speaking members of faith-based groups
- PACE participants
- Chinese-speaking parents of children with disabilities

More Comprehensive

To represent CalOptima's nearly 800,000 members, an in-depth analysis was performed to uncover their unique needs and challenges. An oversampling was thoughtfully incorporated in the calculation of responses needed to achieve a true statistical representation of the Orange County Medi-Cal population. For the mailed survey, more than 42,000 members were selected within a specific sampling frame that included language, age range and region.

With the oversampling, the aim was to collect 4,000 responses with targets for each subgroup. The final data collection results were far beyond the goal in every subgroup. More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

The assessment gathered responses from all geographic areas of Orange County, across all age groups and 10 languages. Additionally, the assessment reached new groups of members whose voices have rarely been sought out or heard before, such as young adults with autism, people with disabilities and homeless families with children.

Ultimately, the assessment concentrated on the underlying social determinants of health that have been recognized as factors that impact the health of individuals. The MHNA probed a broader view of members' lives beyond immediate health care needs to explore issues related to:

- ☑ Hunger
- ☑ Child care
- ☑ Economic stress
- ☑ Housing status
- ☑ Employment status
- ☑ Physical activity
- ☑ Community engagement
- ☑ Family relationships
- ☑ Mental health
- ☑ Personal safety
- ☑ Domestic violence
- ☑ Alcohol and drug use

More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

More Engaging

The MHNA used a mixed-methods approach to engage members who generally have been underrepresented in previous assessments as well as community stakeholders who work directly with the Medi-Cal population. The data collection effort was extensive, incorporating both qualitative and quantitative methods and going beyond previous processes in Orange County. The mixed-methods approach consisted of the following:

Member Survey

5,815 members completed an in-depth 50-question survey that was available in each of CalOptima's seven threshold languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic. As described further below, three additional languages that are less common in Orange County were also incorporated to ensure the assessment was comprehensive. Most surveys were completed and returned via mail (86 percent), with 9 percent completed via telephone and 5 percent online. Telephone calls were made to reach members who were homeless or more transient and may not have a permanent address. An online survey was offered for members' convenience.

Provider Survey

An online survey of 20 questions was sent to a broad sample of providers in CalOptima's network to seek insight on the challenges that members face. Providers identified what they perceive as the top problems for Medi-Cal members as well as barriers for these members in accessing health care. There were 21 network or physician medical groups that completed the provider survey.

Focus Groups

31 focus groups were conducted with members in partnership with community-based organizations across Orange County. Focus groups allowed for face-to-face conversations with members in comfortable and familiar environments, which helped to foster organic, open-ended discussions where members felt safe to share their thoughts. The discussions were conducted in CalOptima's seven threshold languages, as well as Cambodian, Marshallese and American Sign Language. Focus group conversations covered numerous key topics, including quality of life, community assets, barriers to accessing care, violence, behavioral health, chronic disease, and health practices, such as healthy eating and active living.

Key Stakeholder Interviews

24 leaders from community-based organizations participated in the interviews. Those chosen for the study have direct interactions with Medi-Cal members or serve as advocates for Orange County's vulnerable population. Interviews focused on key health issues facing Medi-Cal members, the provision of culturally competent services, and the social determinants of health, such as economic and environmental factors.

In the spirit of collaboration, individuals and groups in the community came together in a remarkable way to demonstrate their dedication to CalOptima members. Countless hours were spent planning, engaging and meeting with members. For example, in addition to serving as stakeholder interviewees, many of CalOptima's community partners reached out to members to encourage them to respond to the surveys, and they also hosted and recruited members to focus group meetings. Community organizations were invaluable in helping members feel comfortable with the process and in providing another view into members' lives. The engagement of community partners and member advocates was instrumental in the success of the MHNA.

More Personal

The MHNA aimed to give CalOptima members a more personal experience by hosting focus group conversations in familiar locations at convenient times, often evenings and weekends. These settings were intentionally selected based on members' comfort levels. Focus groups were also held at specific times to ensure that members could have their voices heard without having to miss work, school or other obligations. Focus groups were conducted in 10 languages enabling members to respond in their preferred spoken language.

Focus groups were held at:

- Apartment complexes
- Churches
- Community centers
- Schools
- Homeless shelters
- Recuperative care facilities
- PACE center
- Community clinics
- Restaurant meeting rooms

Methods

With a strong focus on engaging a representative sample of CalOptima members, Harder+Company and SSRC developed the sample frame to capture a breadth of perspectives as well as focus on the specific needs of key populations. Although the purpose of the MHNA was to assess the needs of Medi-Cal members in Orange County overall, Harder+Company and SSRC sought to gain a better understanding of the needs of CalOptima's non-English speakers by purposefully oversampling all seven subgroups. The oversampling of members designated as speaking one of the seven threshold languages ensured that CalOptima and community stakeholders can be 95 percent confident that the true population parameters for any particular subgroup will fall between +/- 5 percent of the observed sample estimate.

At more than 5,800 members, the survey response far exceeded the target number of respondents in the sampling frame. The robust response was due to a comprehensive data collection plan that included communication with members and partners in advance of sending the survey, reminder phone calls and multilingual computer-assisted telephone interviewing for members preferring to respond by phone.

Survey data was entered, monitored and quality checked by SSRC before being exported for analysis by Harder+Company. All variables were screened to determine the amount of missing data, and basic frequencies were initially computed for each question by language, region and age. To adjust for the oversampling built into the sampling frame, comprehensive statistical analysis was then completed applying weights calculated by SSRC. Additional analysis included collapsing of questions, construction of scale scores and cross-tabulations.

Exhibit 1: Distribution of Completed Surveys and CalOptima Population by Language, Region and Age

Language	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
English	658	11.3%	55.5%
Spanish	715	12.3%	28.6%
Vietnamese	981	16.9%	10.3%
Korean	940	16.2%	1.4%
Farsi	743	12.8%	1.1%
Arabic	648	11.1%	0.6%
Chinese	731	12.6%	0.5%
Other	399	6.9%	2.0%

Region	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
Central	2,315	39.8%	51.5%
North	1,947	33.5%	32.4%
South	1,538	26.4%	15.1%
Out of County	15	0.3%	1.0%

Age	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
0–18 years old	1,665	28.6%	41.8%
19–64 years old	2,453	42.2%	47.2%
65 or older	1,697	29.2%	10.9%

KEY FINDINGS

Given the scope and depth of the study, the MHNA revealed many key findings, which will all be included in the final, comprehensive report. This Executive Summary shares five **key findings**, including related **bright spots** and **opportunities**. Bright spots are CalOptima and community-based resources that already serve to support health behaviors and outcomes. CalOptima can nurture, leverage and build upon these assets. **Opportunities** are areas that CalOptima and its partners can strengthen to positively impact the health and well-being of members.

KEY FINDING: SOCIAL DETERMINANTS OF HEATLH

Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

Given that Medi-Cal eligibility is income-based, it is not surprising that many CalOptima members struggle with economic insecurity. In fact, 55.7 percent of members receive some form of public benefits (Exhibit 2). Further, in the past six months, more than one-quarter of members indicated they needed help with food (32.4 percent), housing (24 percent), money to buy things they need (43.1 percent) and transportation (28.8 percent) (Exhibit 3). Economic stress and financial insecurity cause members and their families to make tradeoffs, such as living in more dense and overcrowded housing with limited space for play and exercise, buying cheaper but less healthy food, or not going to the doctor despite wanting to.

Exhibit 2: Percent of members who receive public benefits (n=5,117)

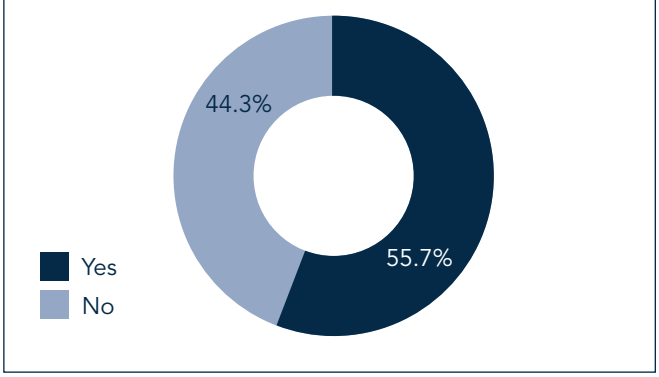
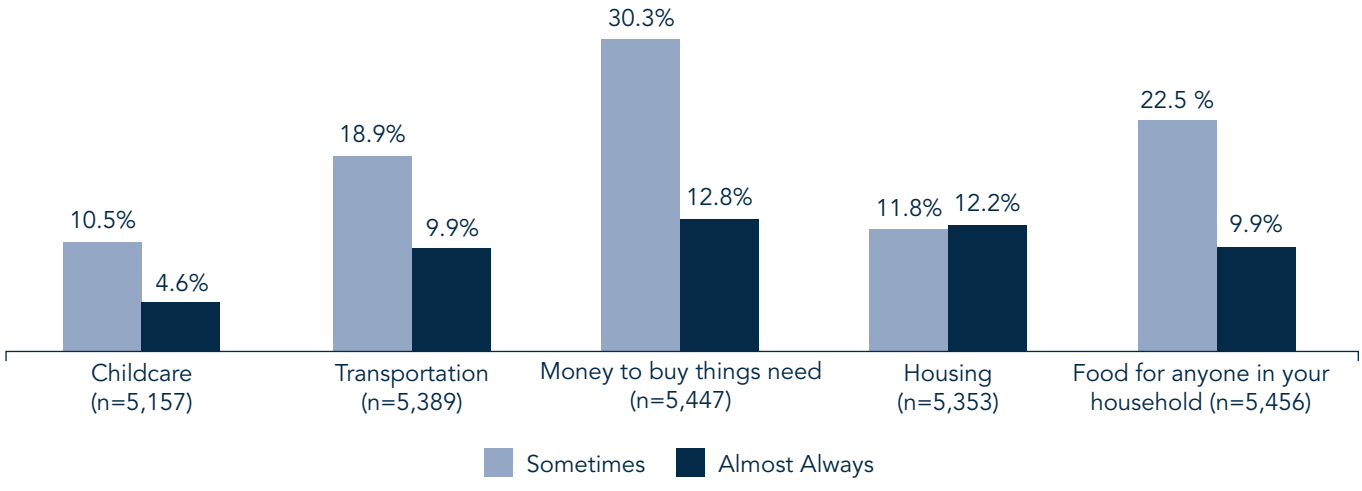
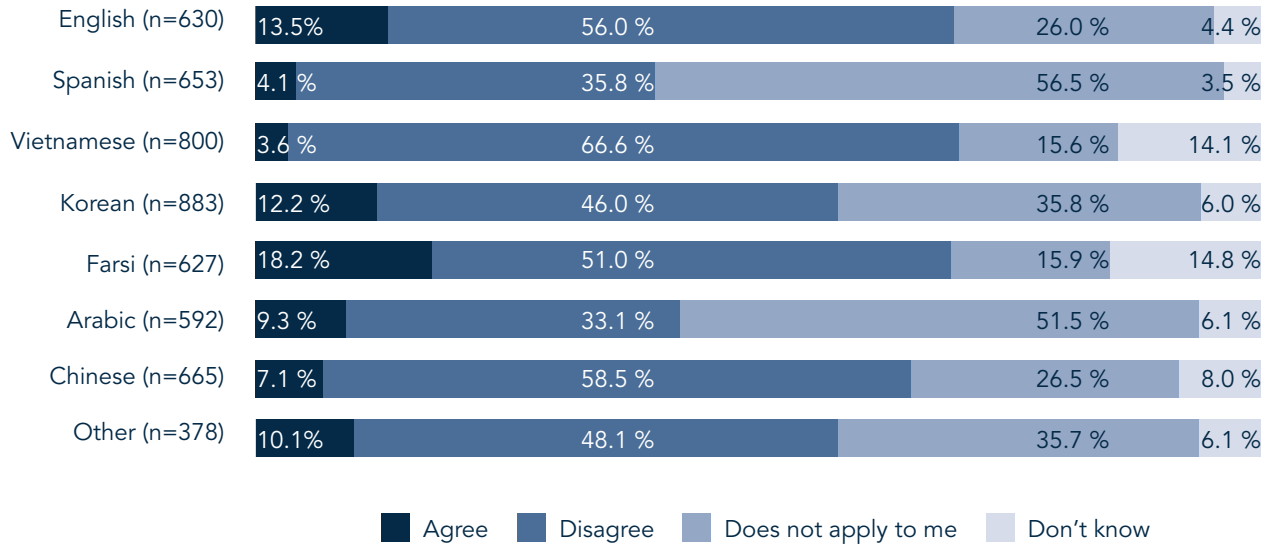


Exhibit 3: Percent of members who needed help with basic needs in the past six months



Social isolation negatively impacts the overall health and well-being of some CalOptima member populations. Social isolation is characterized by a lack of social supports and relationships. It occurs for many reasons, including language barriers, immigration status, age, ability and sexual orientation. In focus groups, members described how feelings of being disconnected from the community can lead to depression, lack of follow-up with health care or service providers, and negative health behaviors. In the survey, 10 percent of all respondents indicated that they felt lonely or isolated. Yet there were higher rates among certain populations, with loneliness and isolation affecting more speakers of English (13.5 percent), Korean (12.2 percent) and Farsi (18.2 percent) (Exhibit 4).

Exhibit 4: Percent of those who reported feeling lonely or isolated by language



Environmental factors also contribute to social isolation and other negative health behaviors, such as lack of physical activity. Focus group participants discussed feeling unsafe in their neighborhoods, which caused them to stay inside or to avoid nearby parks and/or other common spaces.

In addition, lack of affordable housing was a major concern to MHNA respondents, and it resulted in living in overcrowded households, neighborhoods with high crime rates, areas with poor indoor and outdoor air quality, and in the most extreme cases, homelessness.

Bright Spot: CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health a priority, not a lack of knowledge or concern.

Opportunity: CalOptima has already taken steps to strengthen the safety net for members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand this work would positively impact health outcomes in the long run. CalOptima can ensure that providers and community partners understand the social and economic issues that members face and how to adapt health care services accordingly.

KEY FINDING: MENTAL HEALTH

Lack of knowledge and fear of stigma are key barriers to using mental health services.

About 14 percent of members reported needing mental health services in the past year (Exhibit 5). However, local and national data suggest that the need for mental health services is likely underreported and underrecognized. Among those reporting a need, nearly 25 percent did not see a mental health specialist (Exhibit 6). Members did not seek mental health services for several reasons (Exhibit 7), including not knowing who to call or how to ask for help making an appointment (39.8 percent), not feeling comfortable talking about personal problems (37.5 percent) or concern that someone would find out they had a problem (26.1 percent). These factors, along with data gathered from key stakeholder interviews and focus groups, reflect a fear of stigma associated with seeking mental health services.

Exhibit 5: Percent of members who indicated they needed to see a mental health specialist (n=5,723)

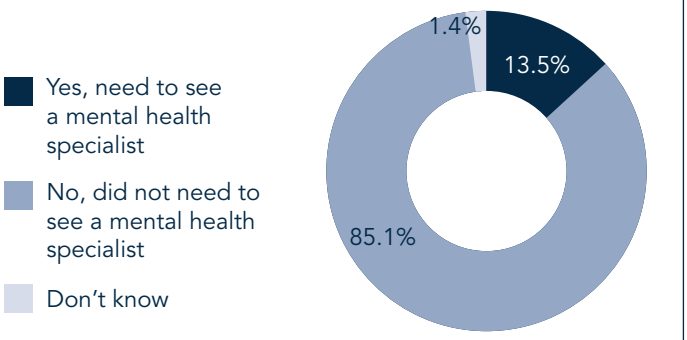
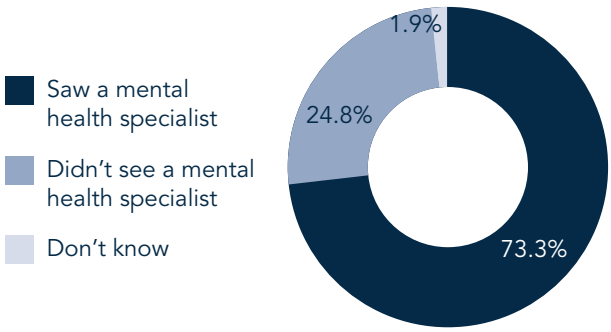
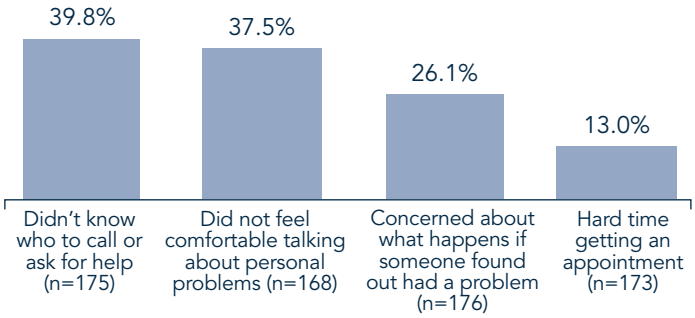


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



Fear of stigma is more prevalent among certain language groups. For example, Chinese-speaking members were more likely to indicate discomfort talking about personal problems and concern about what others might think if they found out about a mental illness than other language groups, followed by Korean-, Vietnamese- and English-speaking members. Conversations with community members and service providers offered cultural context for these findings as many stakeholders described prevalent feelings of shyness, avoidance and shame around discussing mental health issues, let alone seeking care.

Exhibit 7: Reasons why members (who needed to see a mental health specialist but) didn't get services



Bright Spot: CalOptima provides access to mental health services, which meets a clearly established need. Although members needing mental health services do not always connect with providers, many do not do so because of a lack of knowledge, an issue that can be addressed through strengthened connections with existing systems.

Opportunity: Although mental health services are covered by CalOptima, fear of stigma may prevent members from seeking services. This presents an opportunity for CalOptima to continue to provide culturally relevant education around mental health to improve understanding of available services and to address fear of stigma many people face. Community partners with deep knowledge of specific cultural communities are eager to offer support that would increase the use of mental health services.

KEY FINDING: PRIMARY CARE

Most members are connected to primary care, but barriers can make it challenging to receive timely care.

The majority of CalOptima members indicated that they are connected to at least one primary care doctor (82.6 percent), and most go to a doctor's office (69.2 percent) or clinic/health center (18.1 percent) when they need medical attention (Exhibits 8 and 9). However, navigating the health care system can be challenging, and significant barriers make it difficult for people to seek or follow through with care when needed.

Exhibit 8: Percent who report at least one person as their doctor (n=5,749)

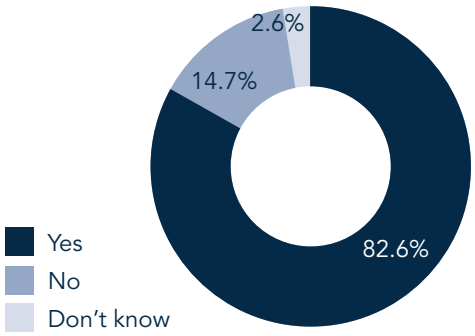
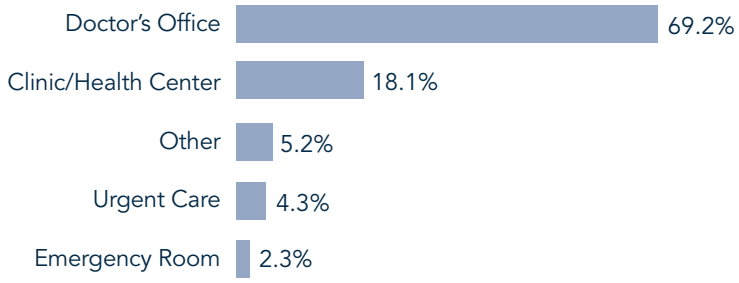


Exhibit 9: Where respondents go to see their doctor (n=5,743)

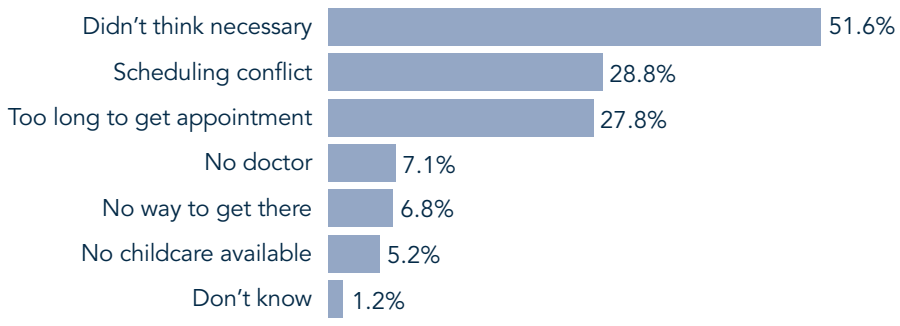


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited hours of operation and inefficiency of public transportation, can make it difficult for people to receive care when needed. When asked why they don't make an appointment to see a doctor, 27.8 percent of CalOptima members indicated that it takes too long to get an appointment while 51.6 percent of members did not think it was necessary to make an appointment (Exhibit 10).

Bright Spot: CalOptima members have access to more than 1,500 primary care providers and 6,200 specialists, as well as 14 different health networks. And staff members are dedicated to continually engaging and educating these providers and networks to ensure they are ready to deliver the care needed by members.

Opportunity: The challenge of maintaining a robust provider network never goes away, and CalOptima must carefully monitor members' access to care. The provider community may be ready to embrace innovations that enhance access, such as extended hours, weekend operations or telemedicine visits, to expand the options for members.

Exhibit 10: Reasons why members don't make an appointment to see doctor (n=4,598)[1]



KEY FINDING: PROVIDER ACCESS

Members are culturally diverse and want providers who both speak their language and understand their culture.

CalOptima members hail from around the globe, reflecting the rich diversity of Orange County's population. In total, 40.3 percent of respondents were born outside of the U.S. and 23.6 percent indicated that they don't speak English well (Exhibits 11 and 12). Among non-English speakers, more than 50 percent were born outside of the United States and many are still acculturating to life in the U.S. This presents challenges when finding a well-paying and fulfilling job, safe and affordable housing, and healthy and familiar food. It also affects the ways members interact with the health care system. In fact, those born outside of the U.S. were significantly less likely to have a doctor and more likely to report feeling lonely or isolated.

Exhibit 11: How well members speak English (n=5,549)

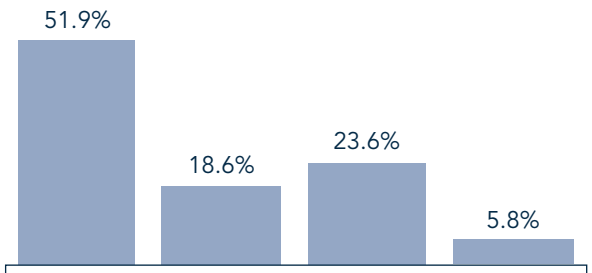
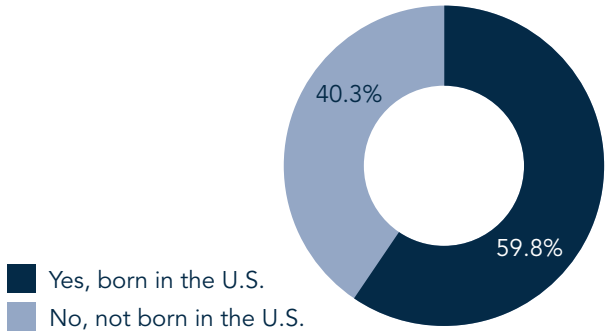


Exhibit 12: Percent of members who were born in the United States (n=5,599)



Further, they report having to adapt to new ways of receiving medical care. Some focus group participants shared that they did not understand why they must wait so long to see a doctor, as it is not this way in their country of origin. Others shared that cultural beliefs and practices made them uncomfortable and often unwilling to see a physician of the opposite gender. In addition, members and key stakeholders indicated that it can be challenging to seek medical care from providers who do not speak members' preferred language, which leads to issues with communication and comfort level. Although many stakeholders highlighted the availability of translation or interpretation services, such services do not always meet members' needs, especially when limited by short appointment times and when sharing sensitive information.

Bright Spot: CalOptima provides services and resources to members in seven languages[2] and can connect members to translation and interpretation services in any language when needed. Members appreciate that CalOptima recognizes the importance of providing care in familiar languages, and they also highly value providers who are sensitive to the cultural norms and practices of their homeland.

Opportunity: CalOptima has an opportunity to build its existing resources and deepen cultural competence of providers and services. CalOptima can engage partners in culturally focused community-based organizations to tailor and implement trainings for providers around specific populations. Trainings can build language and sensitivity skills and increase knowledge in areas such as ethnopharmacology (variations in medication responses in diverse ethnic populations). This can strengthen the workforce and improve member/provider interactions overall.

KEY FINDING: DENTAL CARE

Many members are not accessing dental care and are often unsure about what dental services are covered.

The gap in dental health care is striking and pronounced; 38.2 percent of members indicated they had not seen a dentist within the past 12 months (Exhibit 13). Among those individuals, 41 percent cited cost as the main reason they did not see a dentist (Exhibit 14). Members expressed confusion about dental care benefits available to them via Medi-Cal/Denti-Cal, and they said they would be more likely to seek out a dentist if they knew some of their visits were covered.

Bright Spot: Members in all CalOptima programs are eligible for routine dental care through Denti-Cal, and members in OneCare and OneCare Connect have access to supplemental dental care as well. Better yet, for 2018, California restored additional Denti-Cal benefits, expanding the covered services even further. The challenge is ensuring that members know about these benefits and then actually obtain the services.

Opportunity: To boost the number of members receiving dental care, CalOptima will have to first raise awareness about the availability of services and correct misperceptions that dental care comes at a cost. Further, to remove barriers to care and expand access, the community may embrace the use of alternative providers, such as mobile dental clinics, or the option of co-located dental and medical services.

Exhibit 13: When members last saw a dentist (n=5,685)

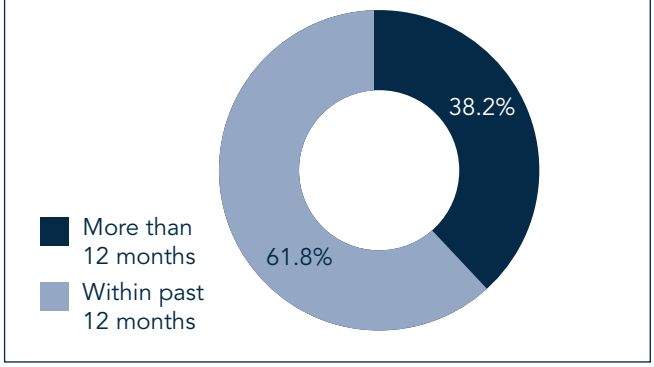
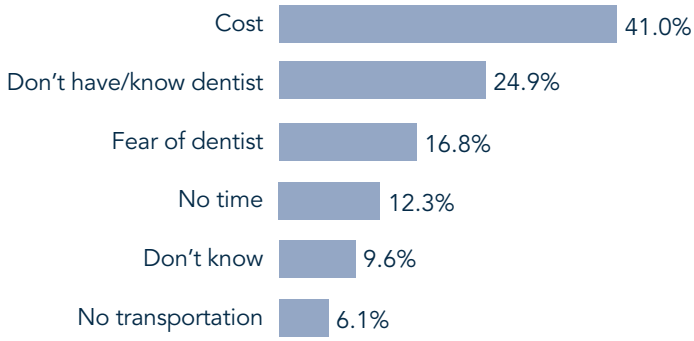


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3][4]



Endnotes

[1] Members could choose multiple answers; thus, the total does not equal 100 percent.

[2] CalOptima provides bilingual staff, interpreter services, health education and enrollment materials in seven languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.

[3] Members could choose multiple answers; thus, the total does not equal 100 percent.

[4] Only reported those who have not seen a dentist within the past 12 months.

January 2018

CalOptima Member Survey Analysis:

Unweighted Estimates by Language, Region, and Age

DRAFT

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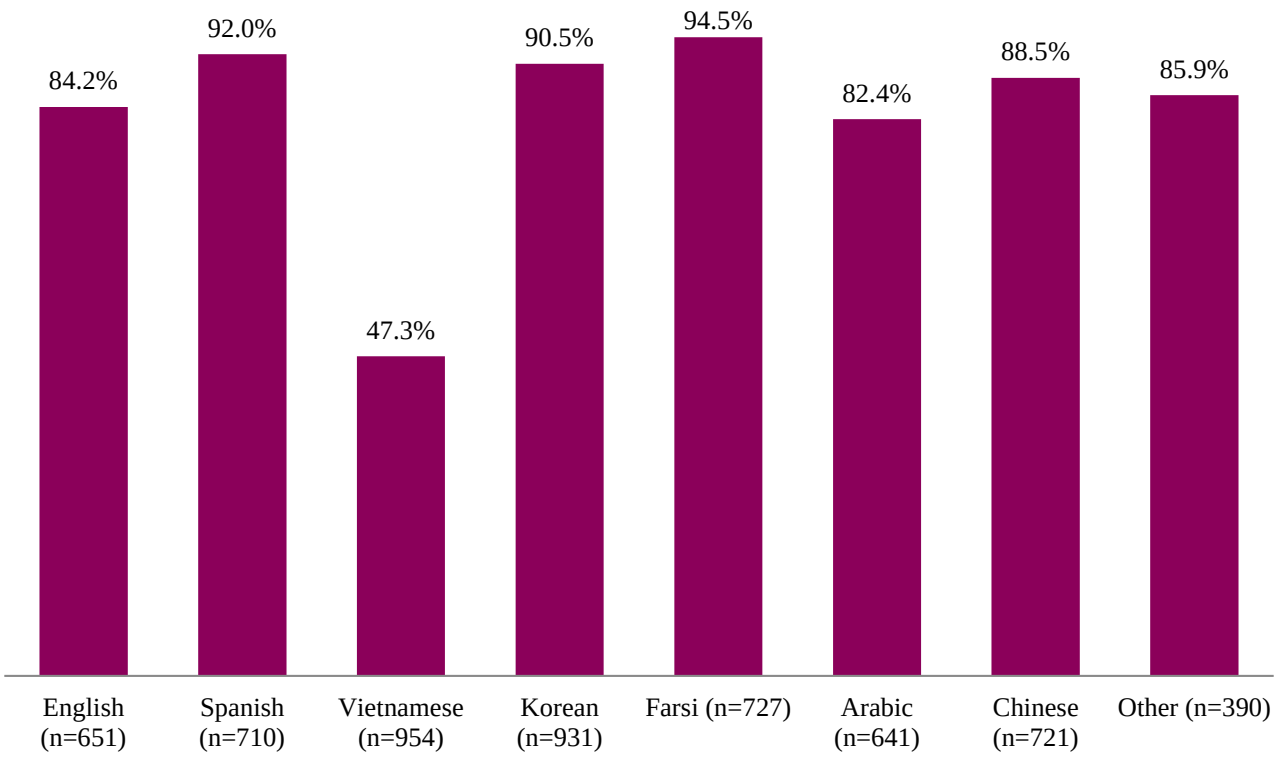
Back to Agenda Back to Item

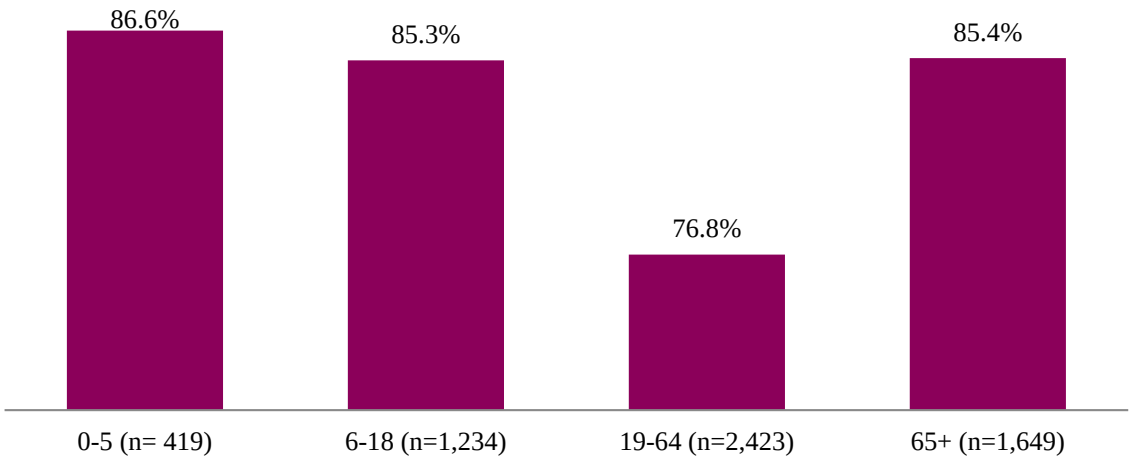
Navigating the Healthcare System

Exhibit 1. Percent who report at least one person as their doctor[1]

CalOptima language:



Age Group:



[1] An issue was identified with the Vietnamese translation of this question. Therefore, results likely misrepresent percentage of Vietnamese members who have a doctor.

Region:

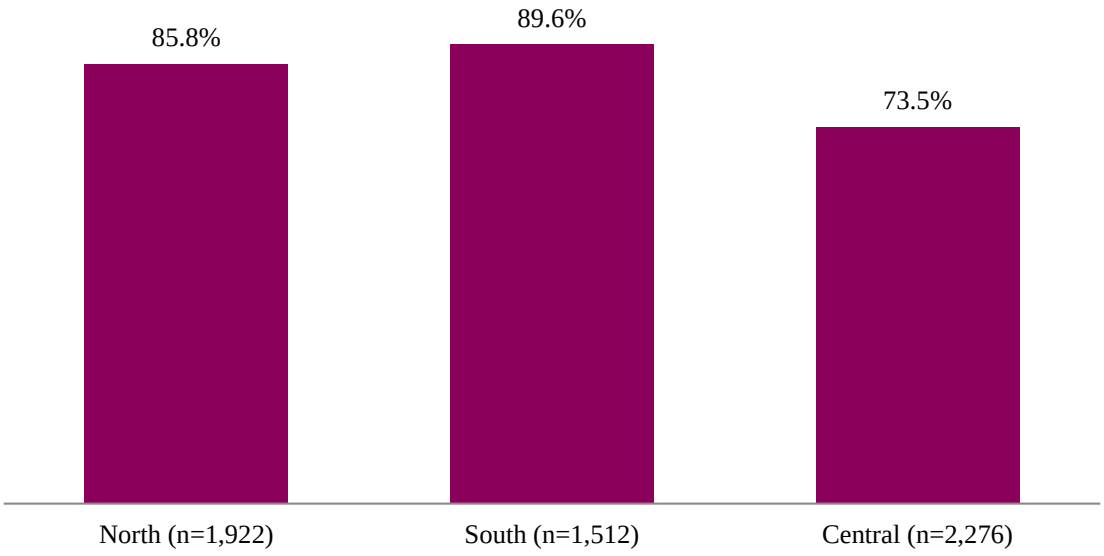


Exhibit 2. Where respondents go to see their doctor

CalOptima language:

CalOptima Language	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
English	71.8%	11.9%	2.0%	6.6%	0.5%	6.4%	0.8%	653
Spanish	59.7%	32.3%	3.4%	1.0%	0.3%	3.1%	0.1%	699
Vietnamese	86.3%	12.0%	0.1%	0.2%	0.0%	1.0%	0.3%	965
Korean	87.8%	4.3%	0.9%	1.1%	0.7%	4.1%	1.2%	938
Farsi	84.0%	6.5%	3.0%	0.8%	0.1%	5.0%	0.5%	737
Arabic	65.3%	15.8%	4.6%	5.4%	0.3%	8.0%	0.5%	625
Chinese	77.2%	11.4%	0.3%	0.8%	0.4%	6.6%	3.3%	727
Other	72.2%	12.6%	1.5%	3.0%	0.0%	9.6%	1.0%	396

Age Category:

CalOptima Age Category	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	68.4%	19.1%	1.9%	2.7%	0.2%	7.2%	0.5%	414
6-18 (Children)	73.0%	16.5%	1.6%	3.0%	0.4%	4.4%	1.0%	1,224
19-64 (Adults/MCE)	73.1%	14.2%	2.6%	2.7%	0.5%	5.5%	1.4%	2,425
65+ (Older Adults)	87.5%	6.8%	0.8%	0.4%	0.1%	4.1%	0.4%	1,677

Region:

CalOptima Region	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
North	74.4%	13.8%	1.7%	3.4%	0.4%	5.4%	1.0%	1,920
South	80.4%	7.9%	2.0%	1.4%	0.5%	6.4%	1.4%	1,521
Central	76.8%	15.5%	1.8%	1.4%	0.2%	3.6%	0.6%	2,284

Exhibit 3. Reasons why members go somewhere other than their doctor when they need medical attention

CalOptima language:

CalOptima Language	I don't have a doctor	It is easier for me to get to the emergency room or urgent care than my doctor's office	It's hard to get an appointment with my doctor	Other	Don't know	n
	%	%	%	%	%	
English	7.4%	26.5%	21.4%	40.7%	4.0%	570
Spanish	7.5%	22.2%	20.1%	37.9%	12.4%	523
Vietnamese	3.1%	31.8%	16.8%	46.2%	2.1%	584
Korean	11.5%	22.7%	27.8%	37.6%	0.4%	687
Farsi	3.1%	15.4%	22.7%	58.8%	0.0%	422
Arabic	5.2%	40.6%	25.5%	28.0%	0.7%	554
Chinese	9.1%	26.8%	14.6%	47.9%	1.6%	549
Other	6.0%	24.9%	16.7%	50.8%	1.6%	317

Age Category:

Age Category	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
0-5 (Children)	4.5%	34.4%	25.4%	29.3%	6.5%	355
6-18 (Children)	5.2%	27.7%	24.0%	36.2%	6.9%	986
19-64 (Adults/MCE)	9.2%	26.0%	23.7%	39.9%	1.3%	1,789
65+ (Older Adults)	4.5%	34.4%	25.4%	29.3%	6.5%	1,076

Region:

Region	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
North	7.4%	27.1%	25.2%	38.4%	1.9%	1,501
South	6.7%	23.1%	20.5%	47.2%	2.5%	1,052
Central	6.3%	28.9%	17.6%	43.2%	4.0%	1,639

Exhibit 4. When do members make an appointment to see doctor[2]

CalOptima Language:

CalOptima Language	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
English	75.8%	77.2%	51.8%	1.1%	4.2%	650
Spanish	77.7%	76.2%	36.9%	0.8%	4.5%	713
Vietnamese	76.0%	74.7%	39.7%	0.1%	1.7%	973
Korean	81.3%	75.2%	47.4%	0.4%	0.6%	938
Farsi	87.4%	80.0%	65.1%	1.8%	3.7%	736
Arabic	82.5%	40.4%	30.9%	0.5%	1.4%	644
Chinese	80.3%	73.6%	48.6%	1.5%	1.2%	727
Other	70.1%	82.0%	51.1%	1.5%	4.6%	395

Age Category:

Age Category	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
0-5 (Children)	86.4%	76.9%	41.9%	0.7%	1.2%	420
6-18 (Children)	81.8%	73.2%	39.9%	0.5%	2.2%	1,236
19-64 (Adults/MCE)	78.0%	67.9%	47.3%	1.1%	2.3%	2,433
65+ (Older Adults)	77.8%	77.4%	50.0%	0.9%	3.4%	1,687

[2] **Members were allowed to choose multiple answers; thus, the total does not equal 100%.**

Region:

Region	When Sick	Check-Up	Specialist Needed	Don't Know	Other	n
	%	%	%	%	%	
North	78.2%	70.5%	43.6%	0.9%	2.3%	1,938
South	83.3%	75.9%	55.9%	1.3%	2.8%	1,527
Central	77.7%	72.0%	41.8%	0.5%	2.5%	2,296

Exhibit 5. Reasons why members don't make an appointment to see doctor[3]

CalOptima language:

CalOptima Language	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
English	7.8%	6.7%	28.0%	27.6%	5.2%	54.0%	1.8%	554
Spanish	6.3%	6.5%	20.8%	27.4%	5.2%	53.2%	0.8%	504
Vietnamese	2.3.%	7.0%	50.9%	24.8%	4.1%	42.8%	0.0%	725
Korean	11.7%	4.1%	48.4%	39.7%	3.8%	31.5%	0.0%	677
Farsi	5.7%	19.5%	24.9%	45.1%	6.9%	33.3%	0.0%	406
Arabic	2.7%	7.0%	28.2%	42.6%	2.1%	37.1%	0.0%	561
Chinese	7.2%	9.6%	29.8%	24.8%	2.2%	51.0%	0.9%	541
Other	4.1%	8.8%	25.0%	29.1%	1.7%	56.8%	0.0%	296

[3] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Age Category:

Age Category	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	4.6%	6.5%	32.8%	35.9%	10.5%	43.7%	0.0%	323
6-18 (Children)	4.8%	4.5%	38.2%	32.8%	3.9%	43.4%	0.1%	990
19-64 (Adults /MCE)	7.8%	7.4%	36.3%	34.5%	4.2%	39.5%	0.8%	1,933
65+ (Older Adults)	4.5%	13.3%	26.1%	26.9%	1.3%	53.2%	0.3%	1,018

Region:

Region	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%			
North	7.6%	7.7%	36.3%	35.0%	3.3%	40.5%	0.3%	1,521
South	6.3%	10.5%	27.5%	35.8%	4.8%	45.7%	0.6%	1,019
Central	4.6%	6.9%	35.9%	28.1%	4.0%	46.1%	0.5%	1,712

Exhibit 6. When do members make an appointment to see a specialist[4]

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
English	76.0%	26.5%	63.5%	638
Spanish	71.9%	30.5%	60.7%	679
Vietnamese	70.3%	24.4%	56.7%	949
Korean	69.1%	27.1%	45.2%	877
Farsi	78.6%	31.4%	55.7%	688
Arabic	68.9%	16.3%	42.5%	631
Chinese	66.0%	35.6%	45.4%	694
Other	79.2%	26.8%	59.9%	384

Age Category:

Age Category	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
0-5 (Children)	71.1%	28.4%	53.8%	394
6-18 (Children)	67.7%	25.7%	52.6%	1,172
19-64 (Adults/MCE)	71.5%	25.2%	54.5%	2,328
65+ (Older Adults)	75.7%	31.3%	51.7%	1,646

[4] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

Region:

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
North	69.3%	27.7%	50.6%	1,857
South	74.3%	28.3%	52.9%	1,453
Central	72.6%	26.6%	55.5%	2,216

Exhibit 7. Reasons why members don't make an appointment to see specialist[5]

CalOptima Language:

CalOptima Language	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
English	19.5%	8.0%	20.4%	27.0%	41.1%	548
Spanish	7.9%	5.5%	12.0%	20.2%	46.4%	560
Vietnamese	11.3%	9.3%	37.8%	30.7%	33.4%	724
Korean	14.2%	12.5%	32.6%	41.5%	27.6%	696
Farsi	13.9%	14.3%	15.2%	37.6%	24.5%	474
Arabic	9.9%	6.9%	21.5%	47.1%	25.6%	577
Chinese	11.9%	14.6%	17.6%	25.4%	42.6%	556
Other	15.6%	12.6%	16.5%	27.2%	39.2%	334

Age Category:

Age Category	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
0-5 (Children)	10.8%	8.1%	22.8%	33.5%	41.0%	334
6-18 (Children)	12.1%	7.9%	27.2%	32.1%	35.9%	1,019
19-64 (Adults/MCE)	13.7%	9.8%	24.9%	35.5%	31.6%	1,953
65+ (Older Adults)	12.6%	13.8%	16.3%	27.6%	37.0%	1,163

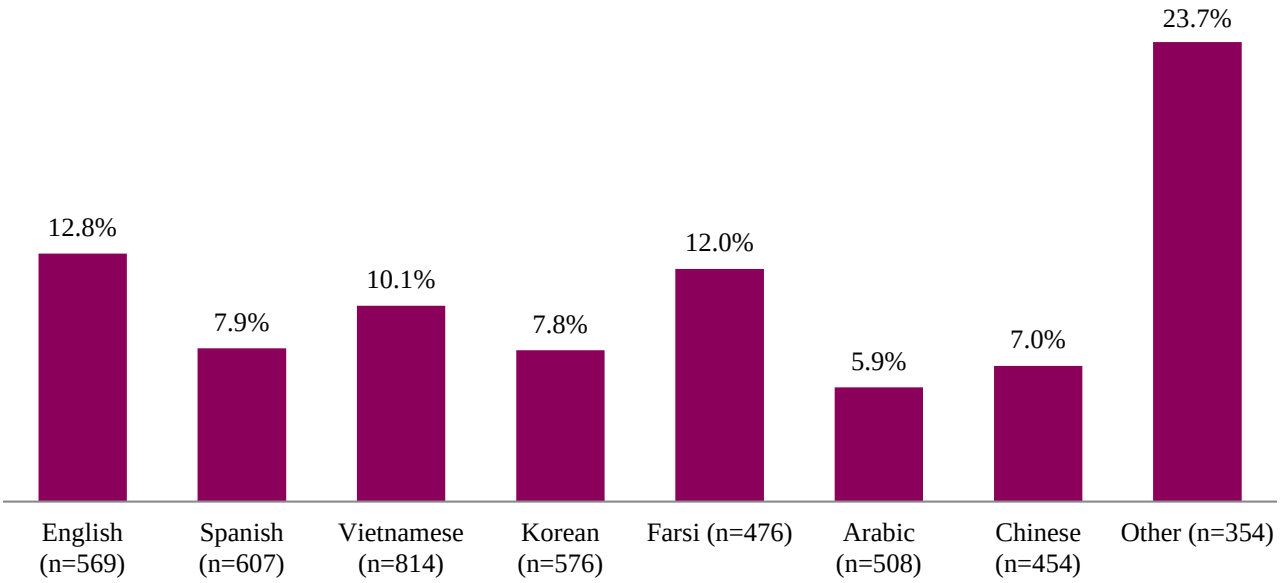
[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Region:

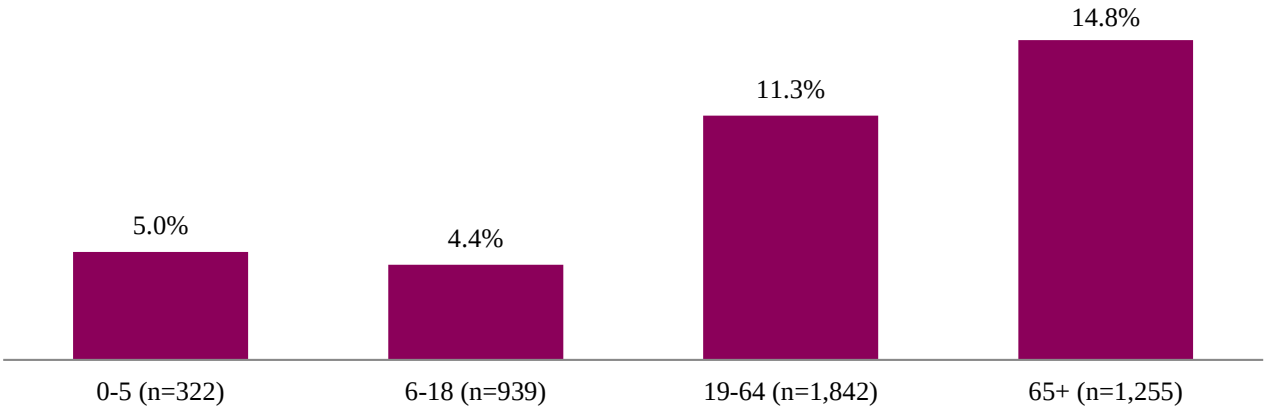
Region	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
North	14.0%	11.3%	24.8%	35.9%	31.1%	1,567
South	13..6%	11.3%	17.5%	33.6%	35.9%	1,097
Central	11.4%	8.8%	24.9%	28.9%	37.2%	1,792

Exhibit 8. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor

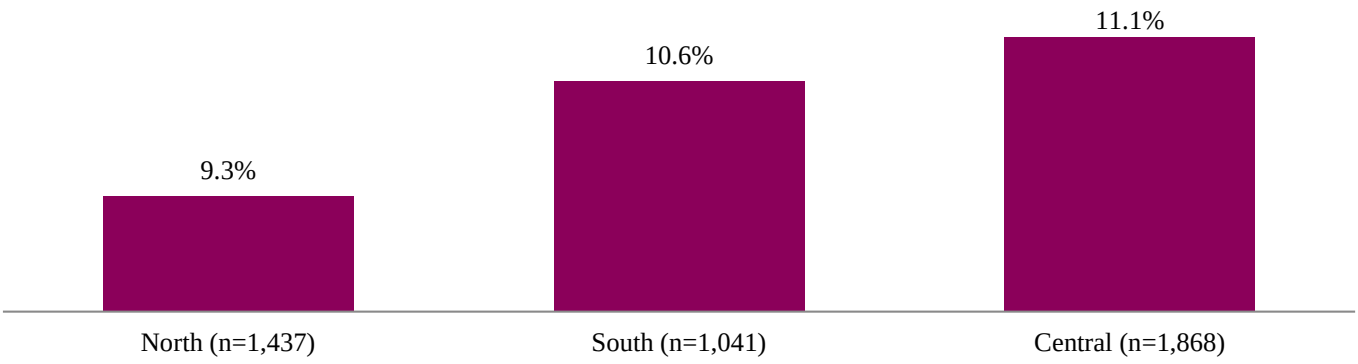
CalOptima language:



Age Category:



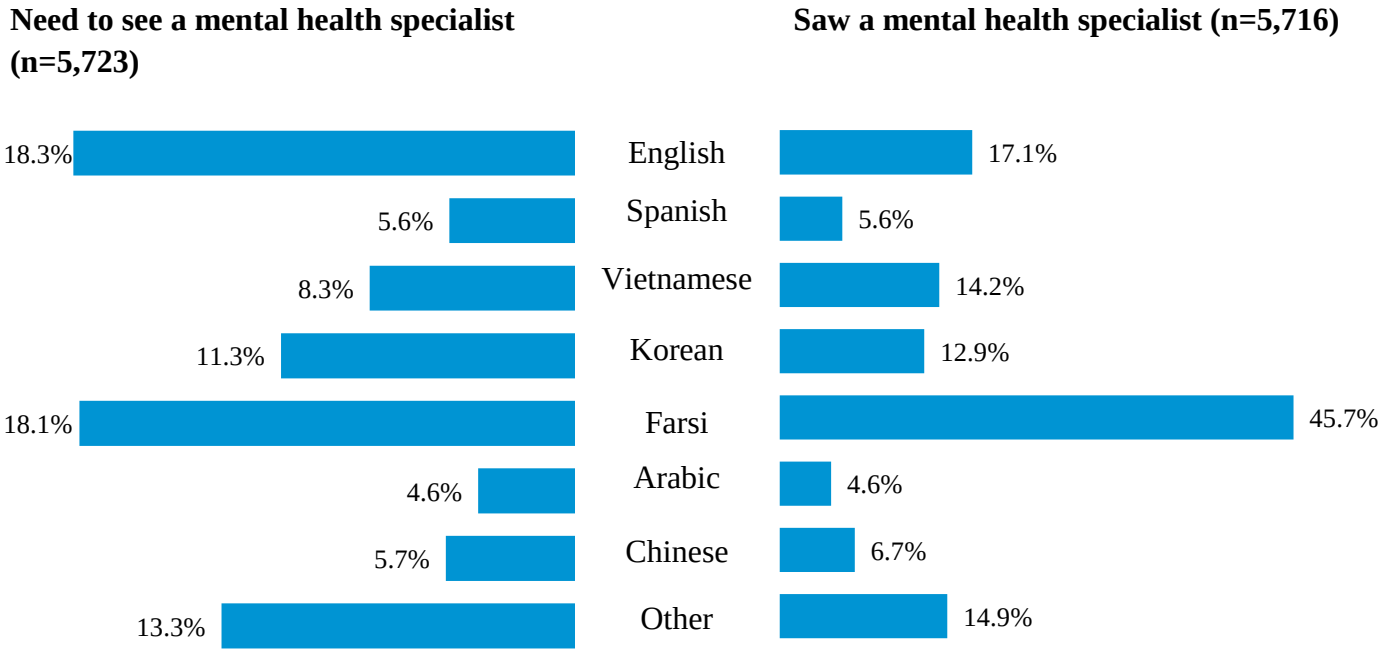
Region:



Social and Emotional Well-Being

Exhibit 9. Members who needed to see compared to those who saw a mental health specialist in the last 12 months[6]

CalOptima Language:

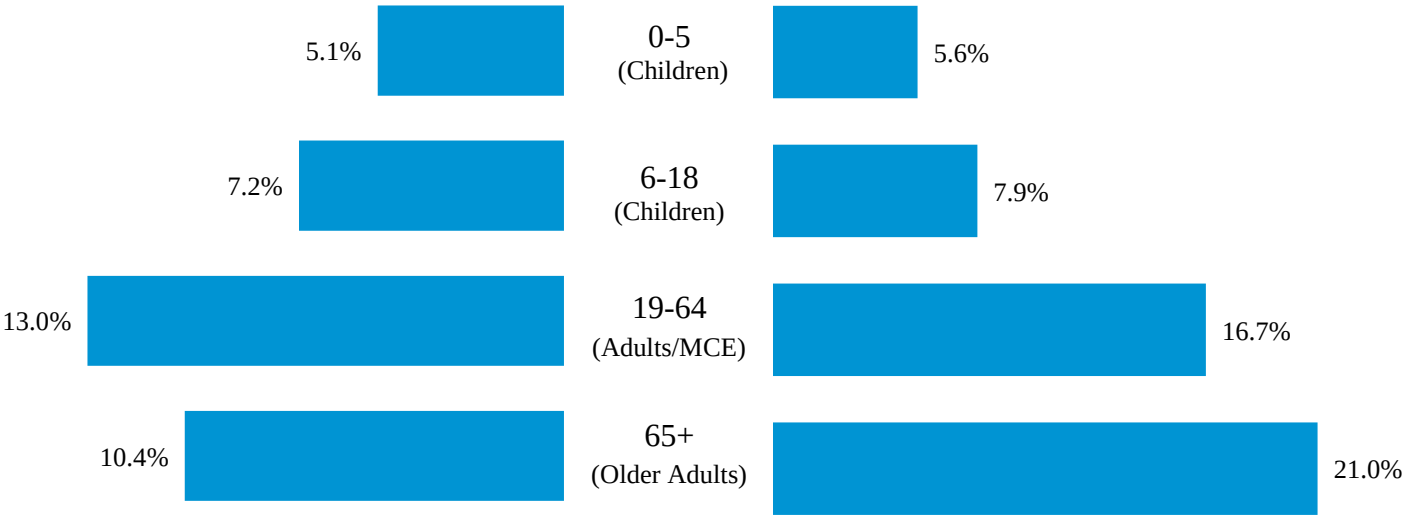


[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

Age Category:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)



Region:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)

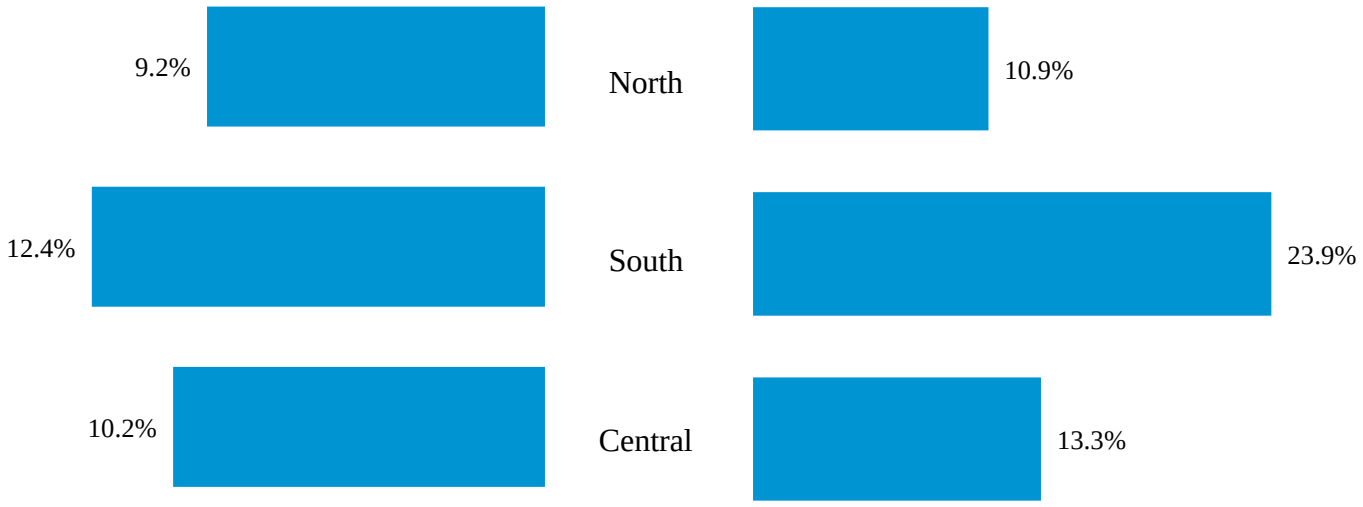
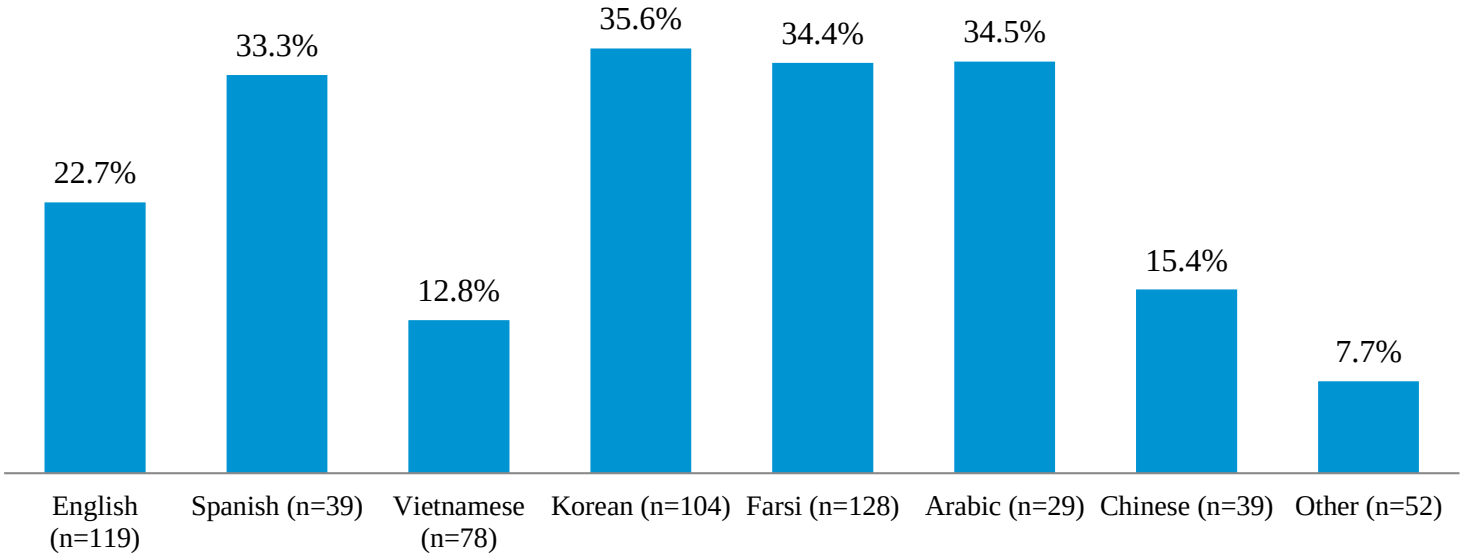
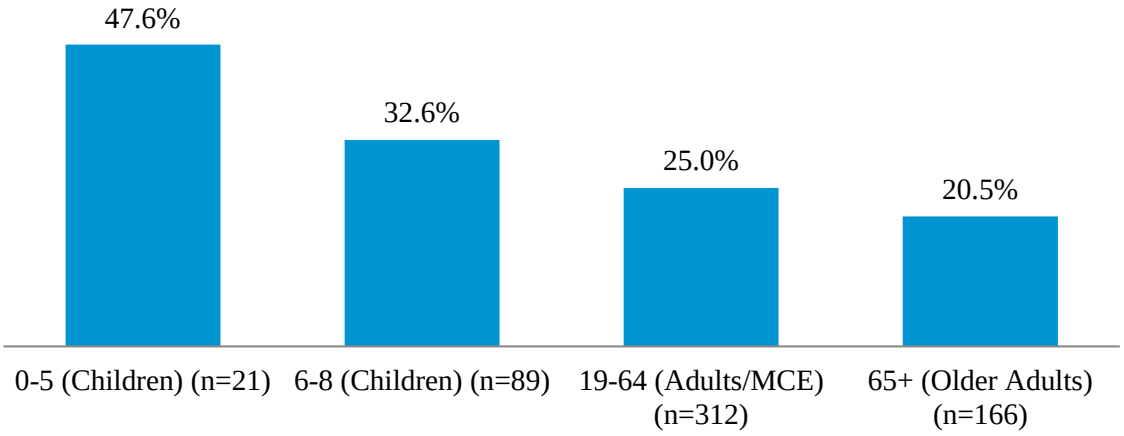


Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist

CalOptima Language:



Age Category:



Region:

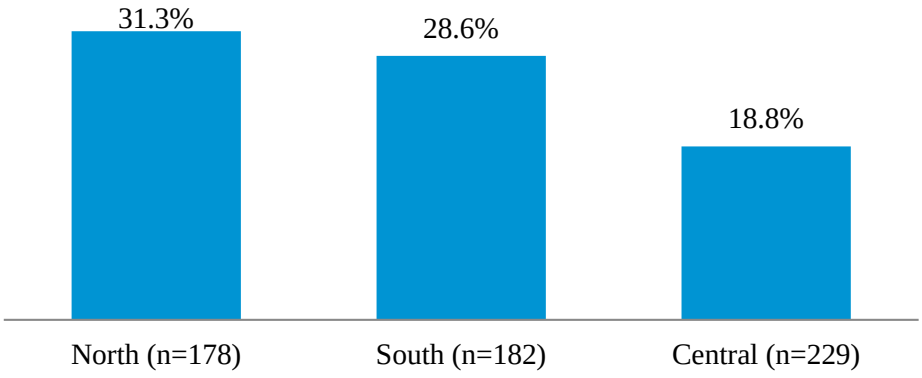
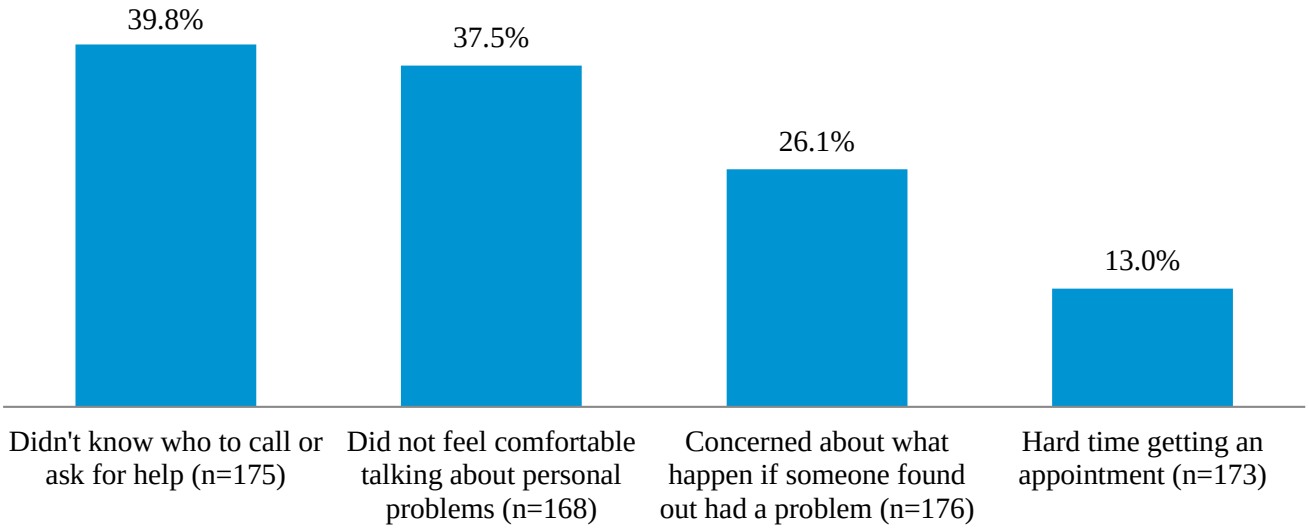


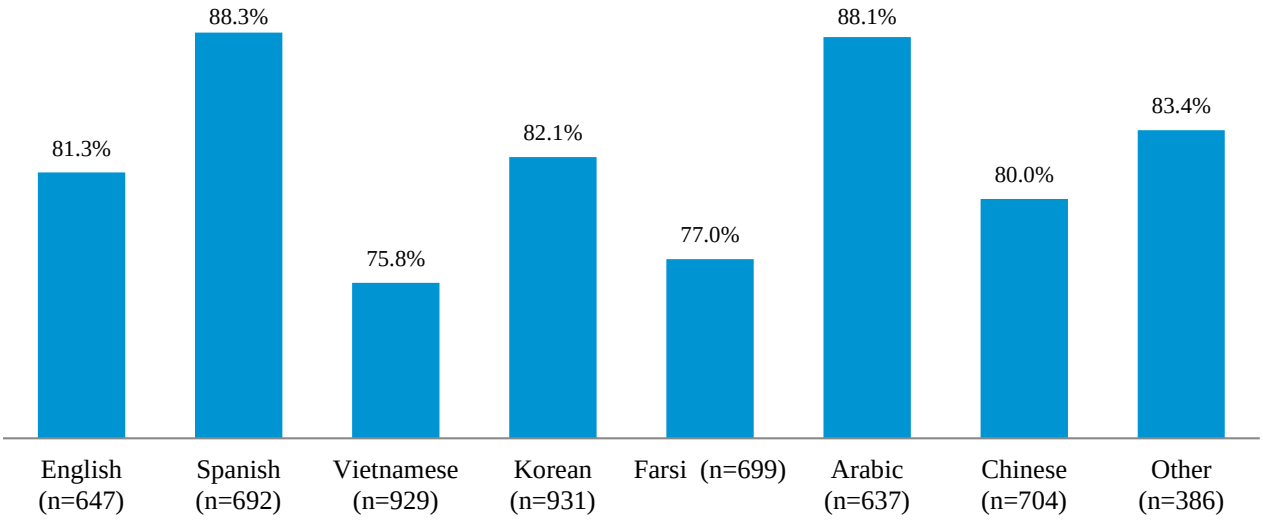
Exhibit 11. Reasons why members didn't see mental health specialist[7]



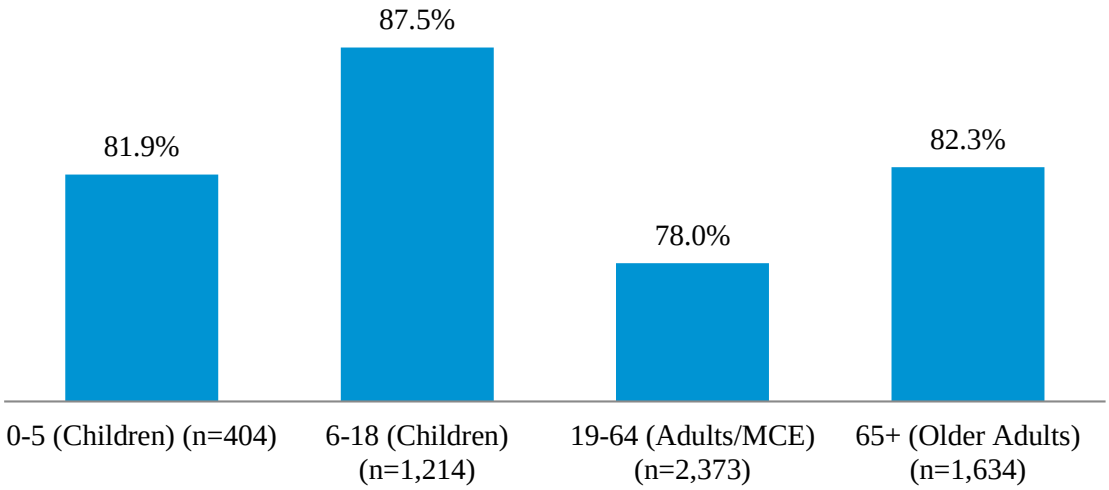
[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

Exhibit 12. Percent of members who can share their worries with family members

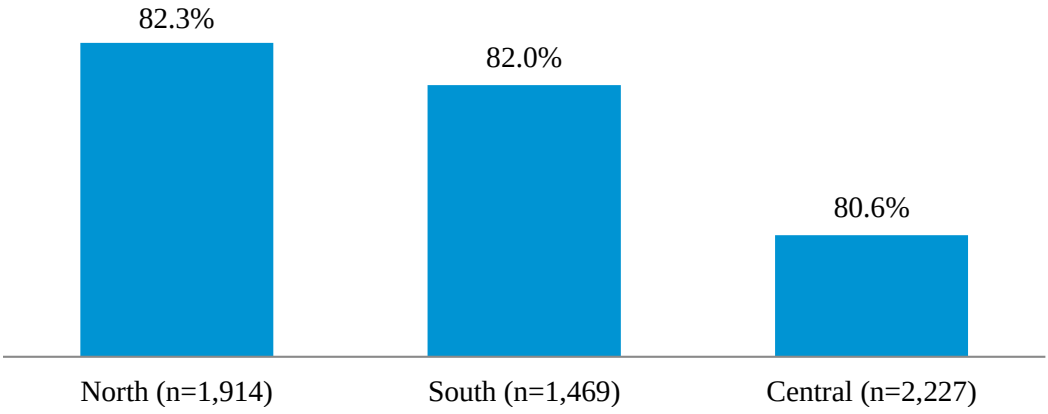
CalOptima language:



Age Category:



Region:

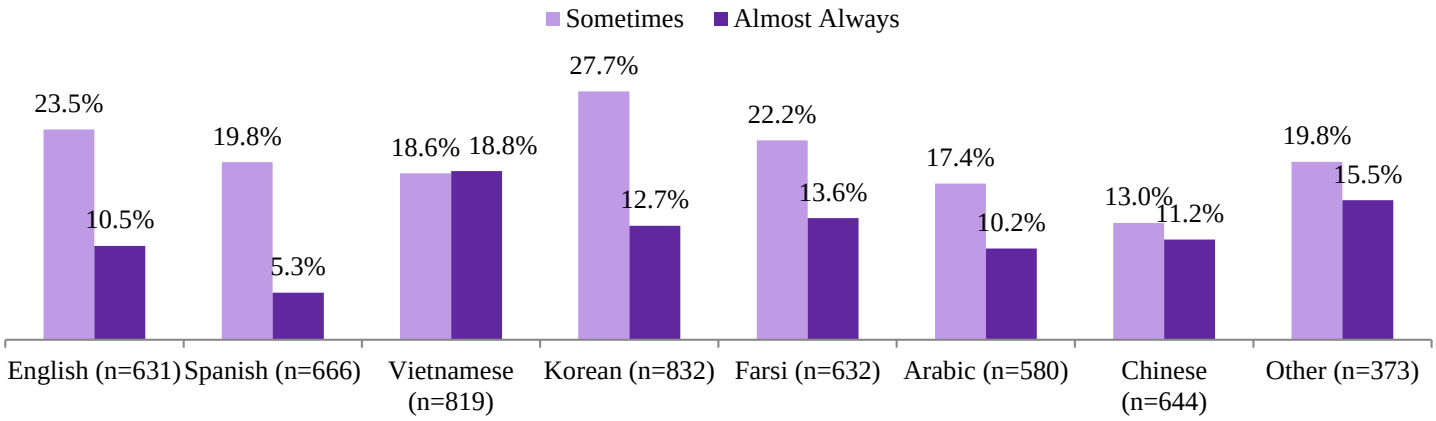


Social Determinants of Health

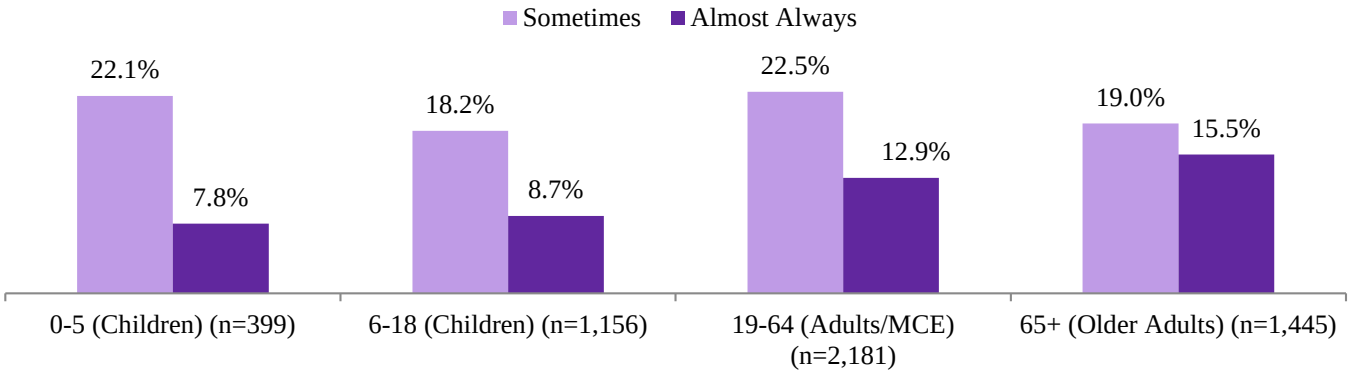
Exhibit 13. Needed help with the following in the past 6 months:

Food for anyone in your household:

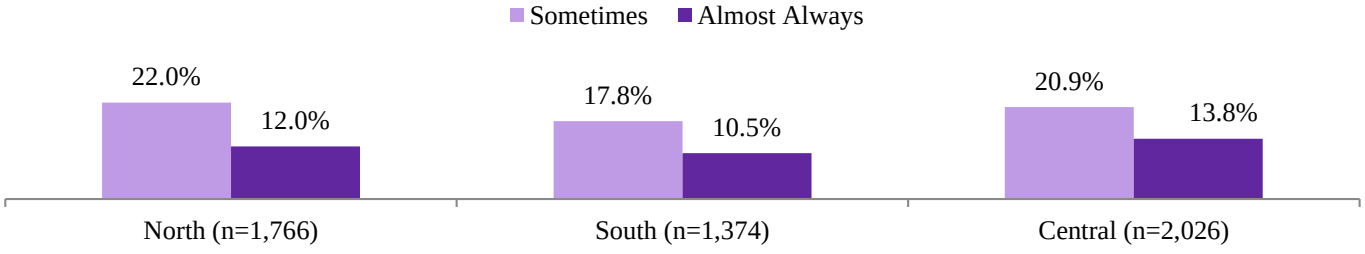
CalOptima language:



Age Category:

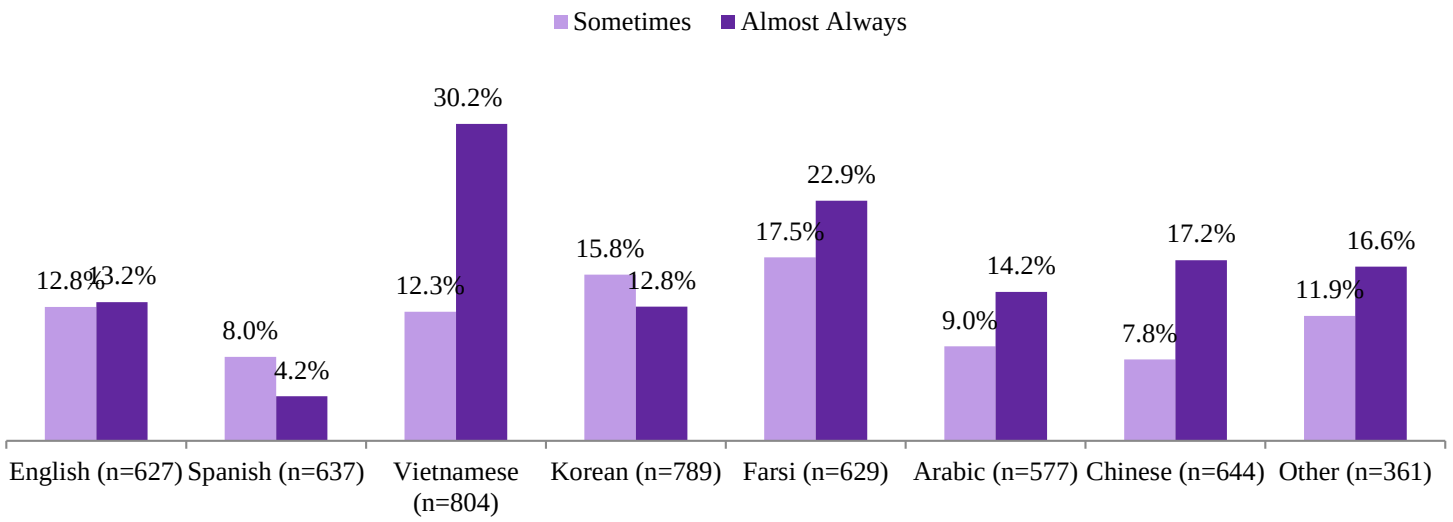


Region:

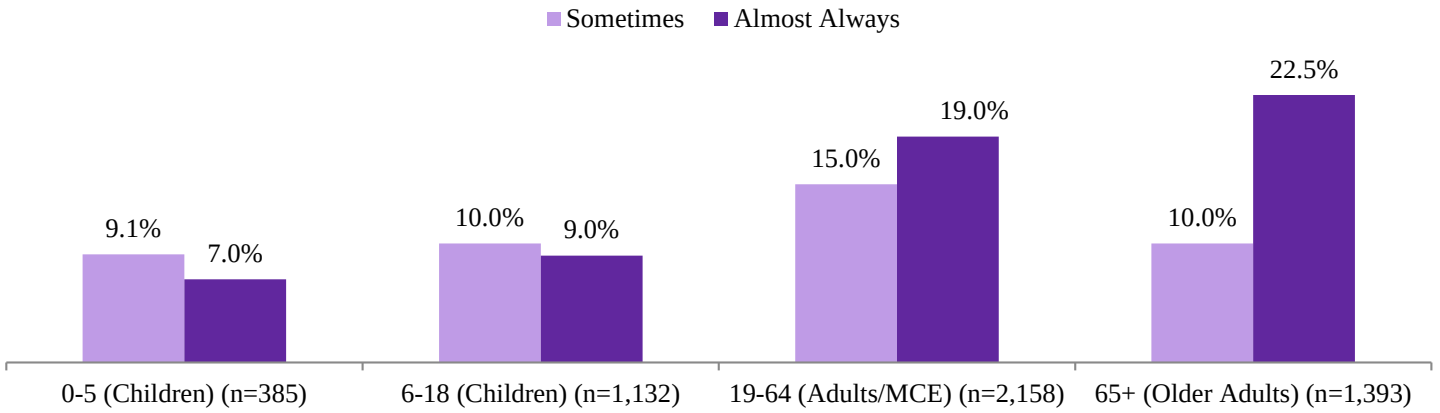


Housing:

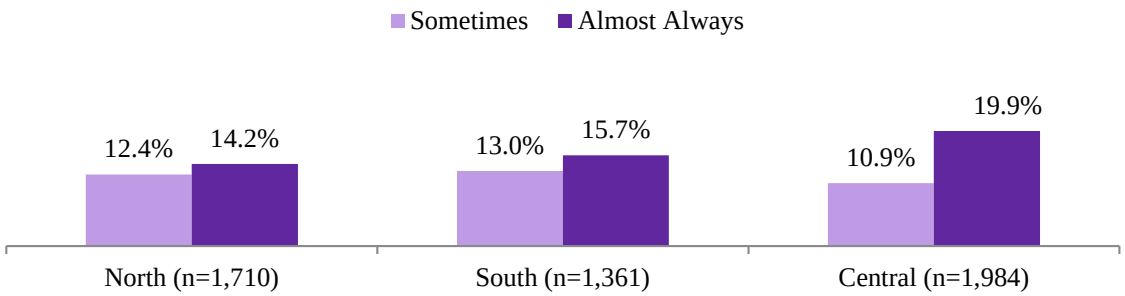
CalOptima language:



Age Category:

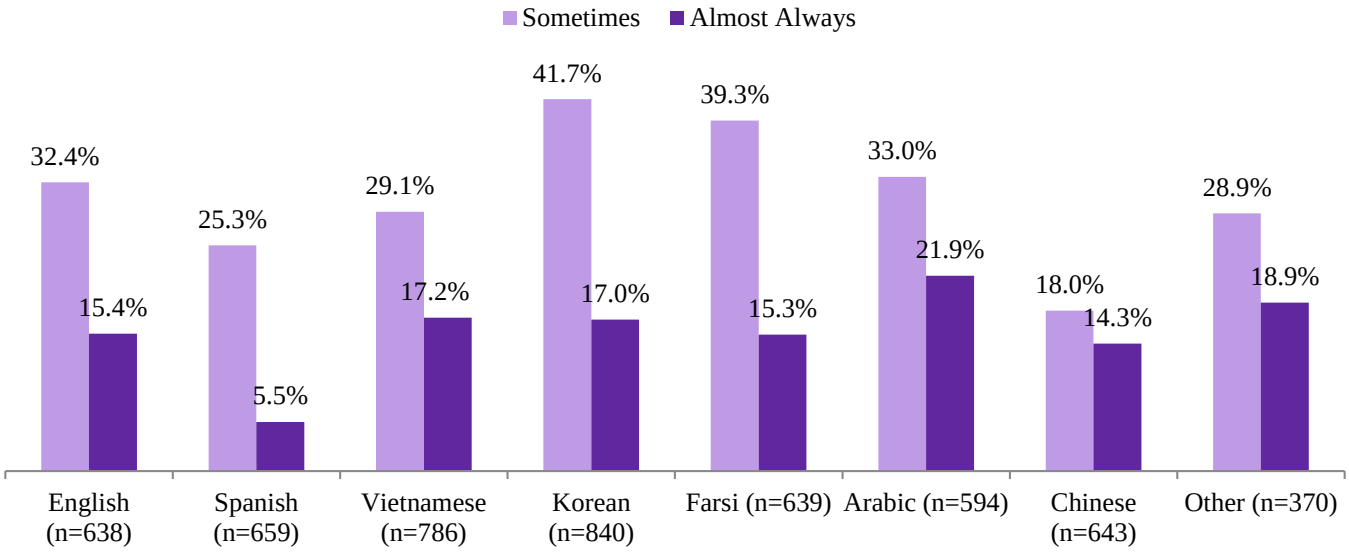


Region:

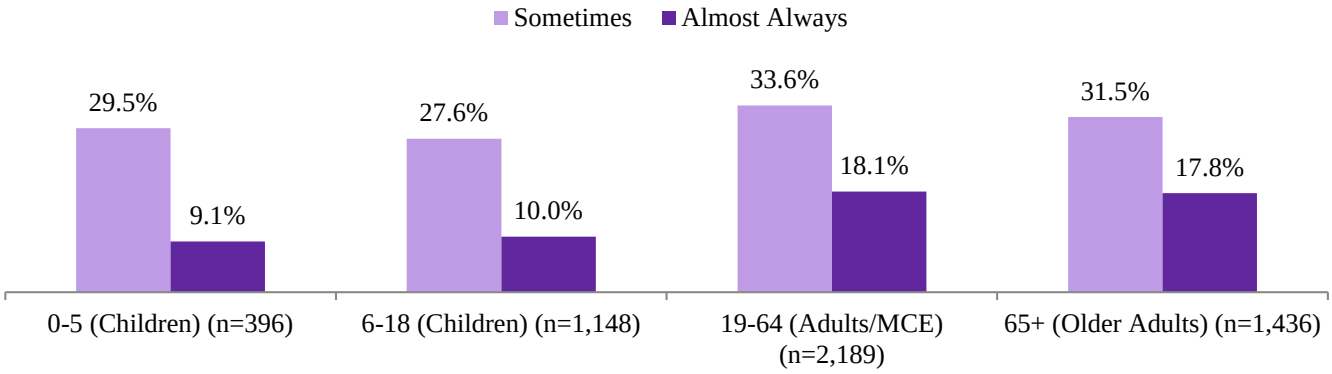


Money to buy things need:

CalOptima language:



Age Category:



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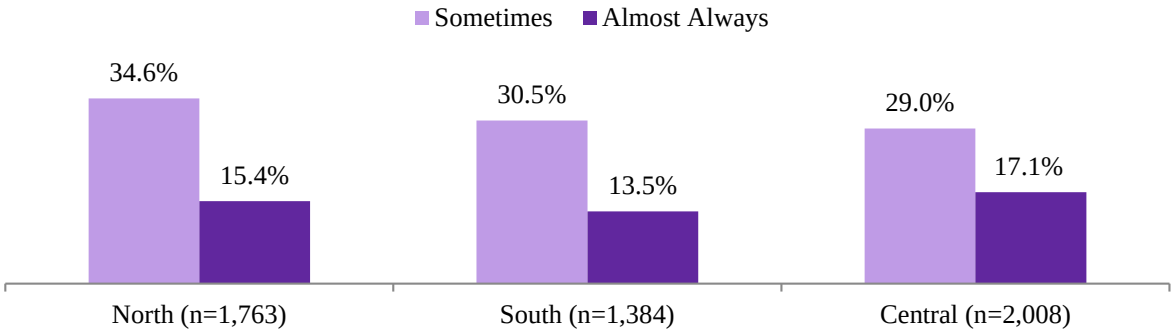
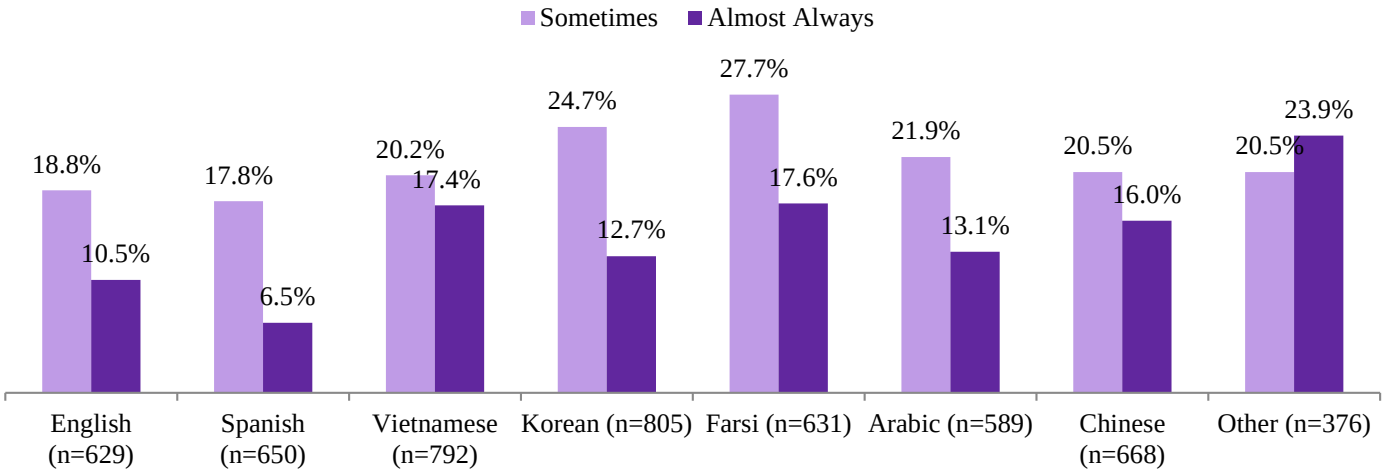
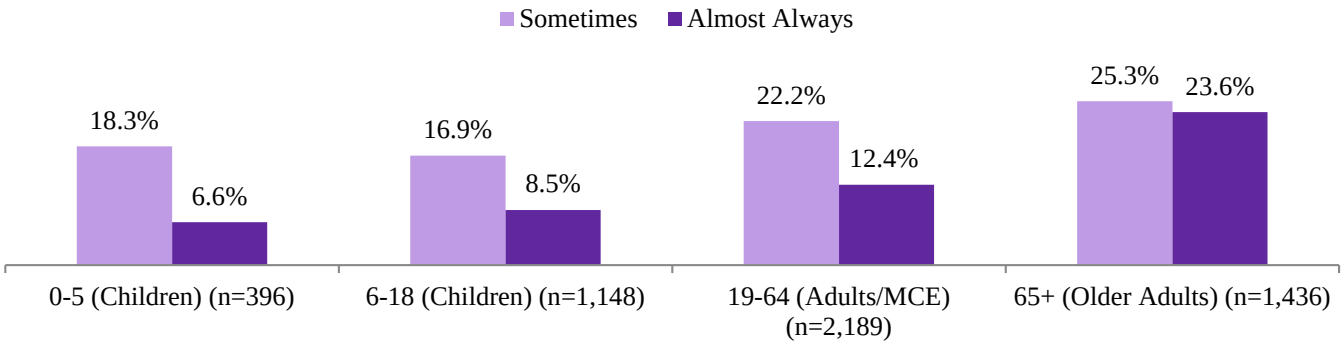


Transportation:

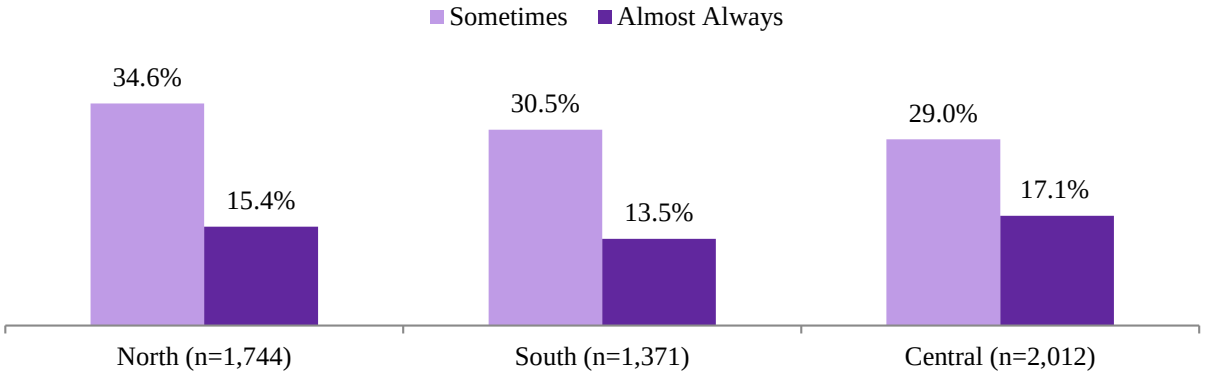
CalOptima language:



Age Category:

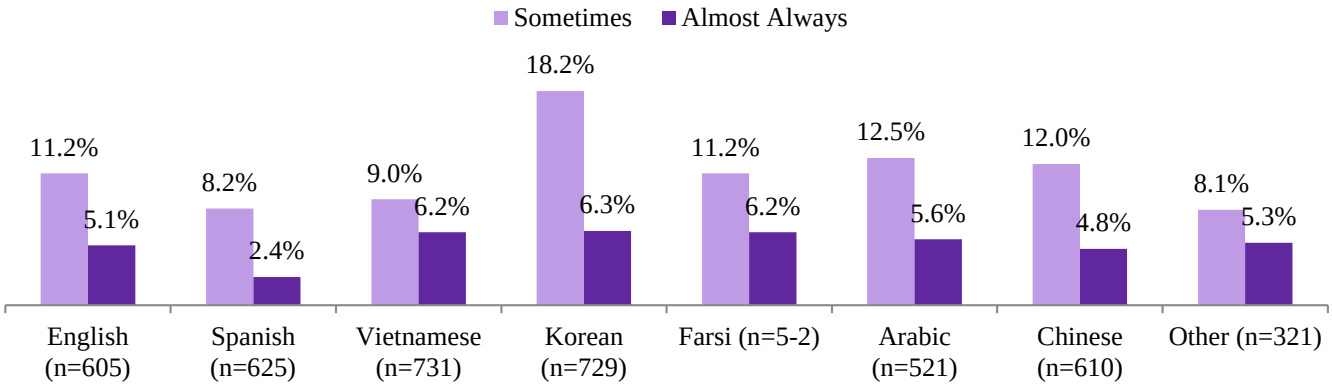


Region:

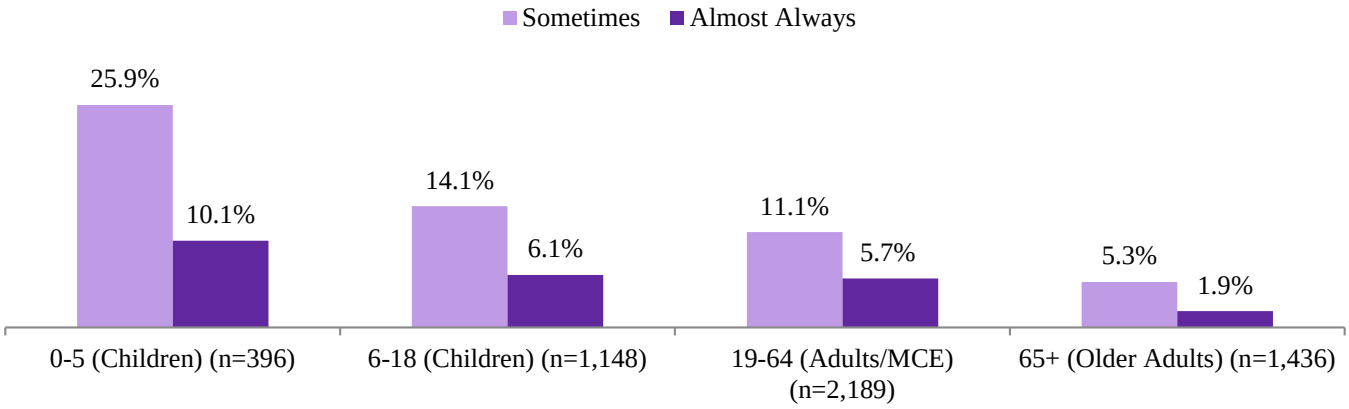


Child care:

CalOptima language:



Age Category:



Region:

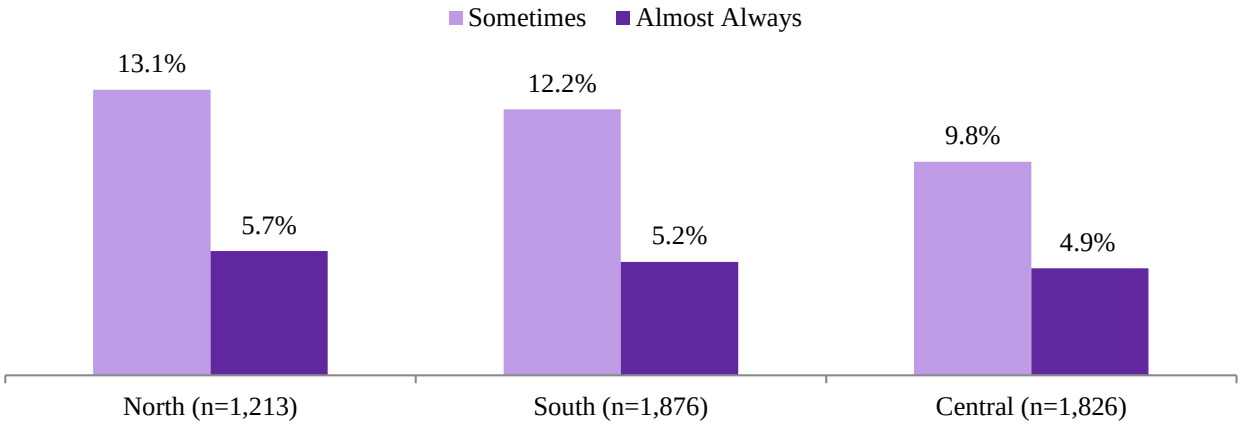
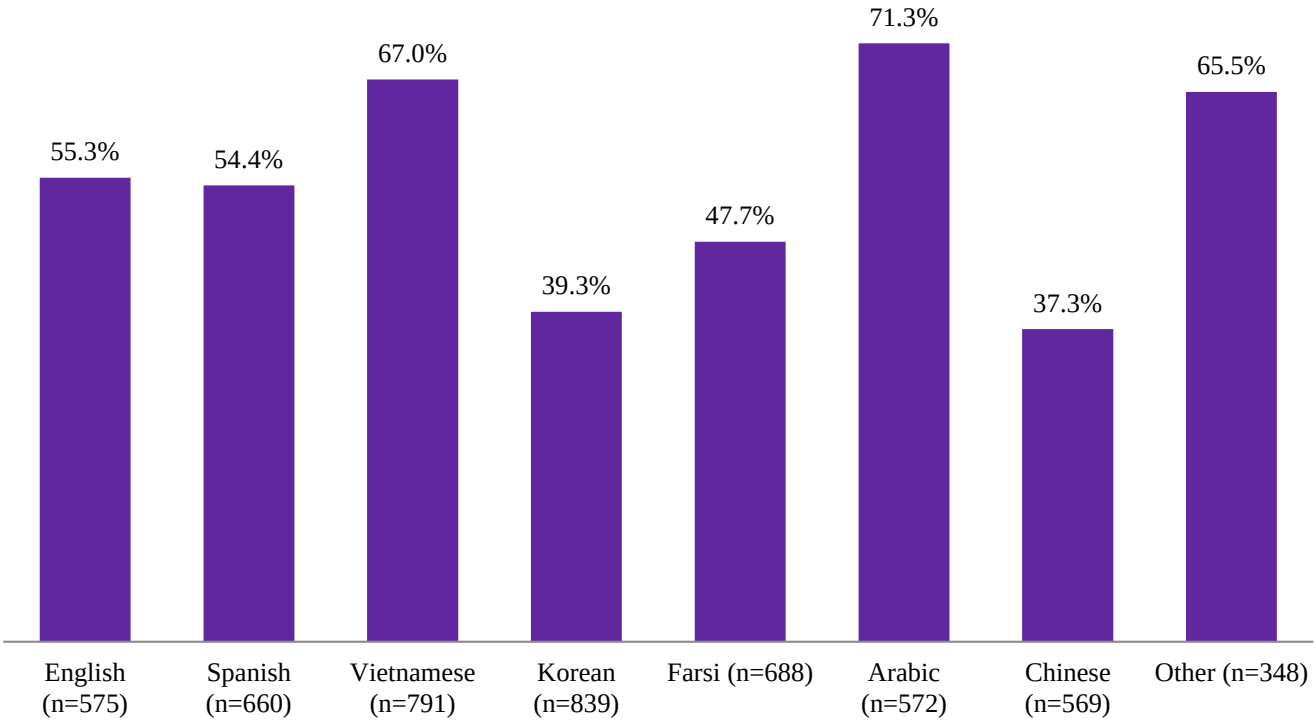


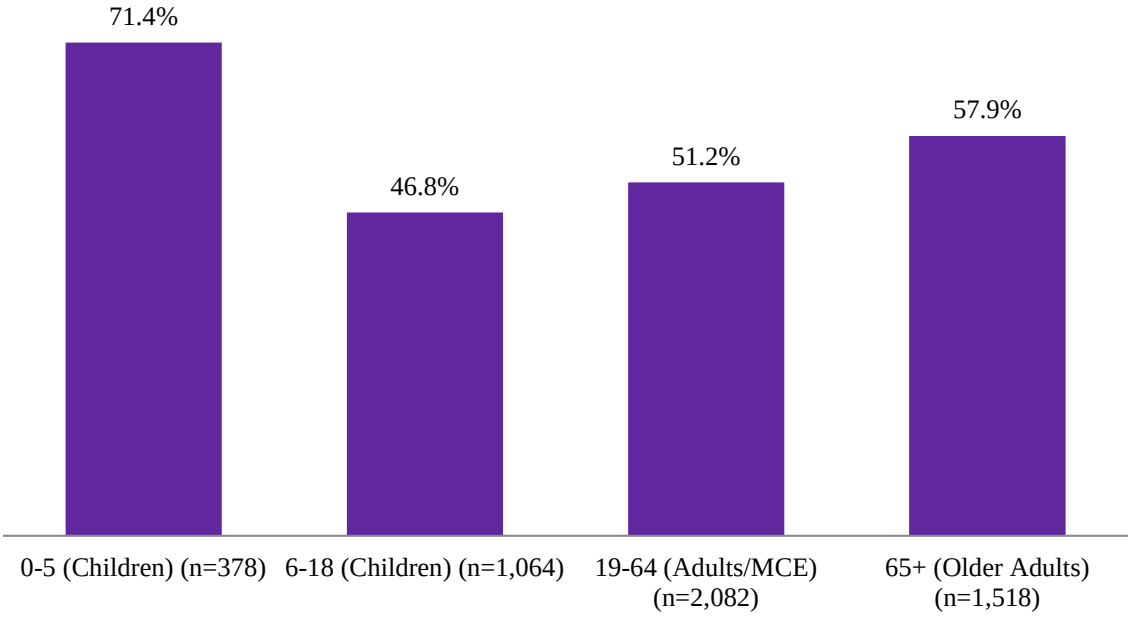
Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

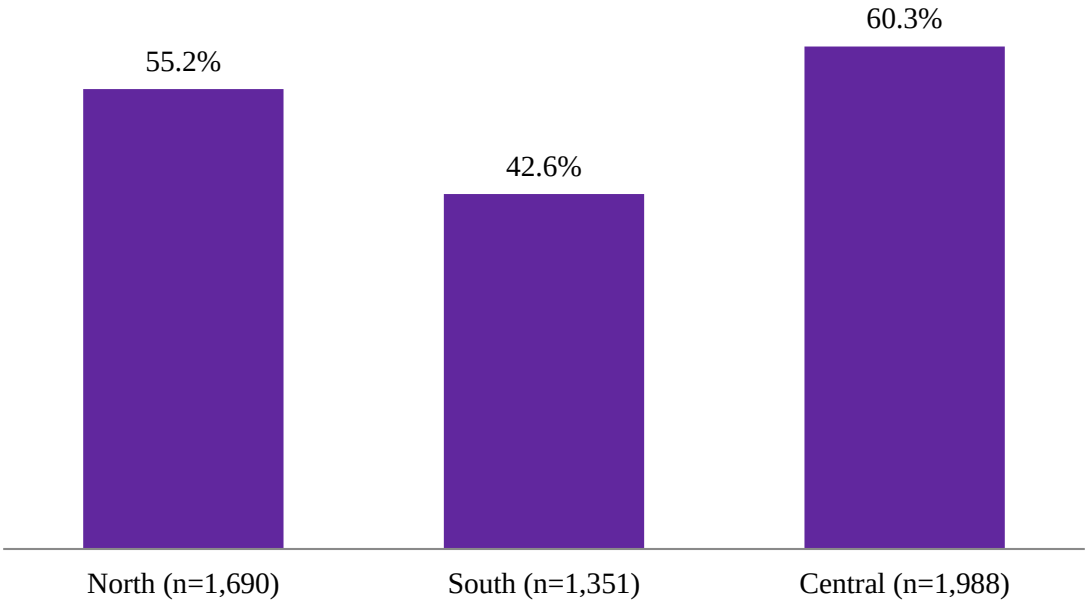
CalOptima language:



Age Category:



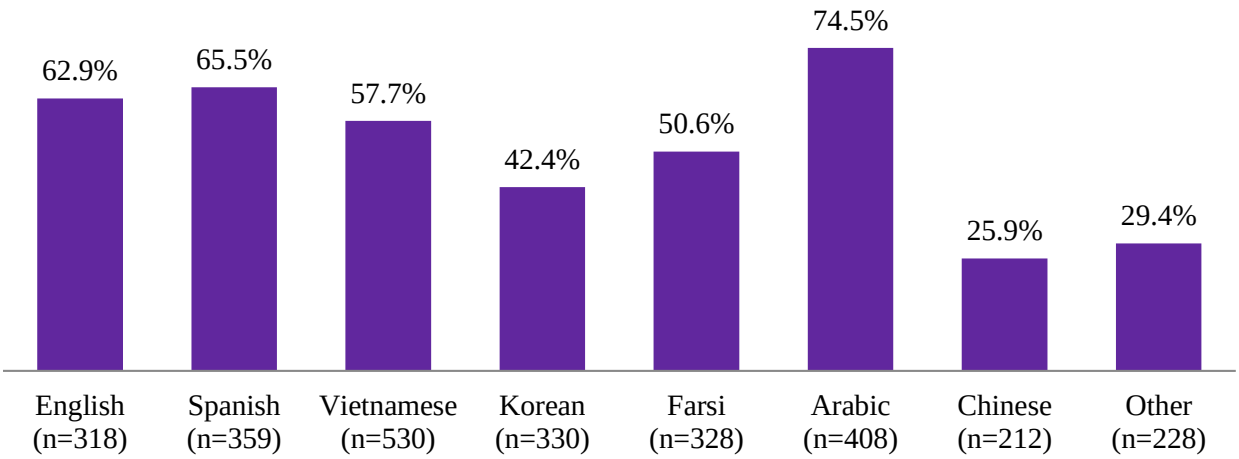
Region:



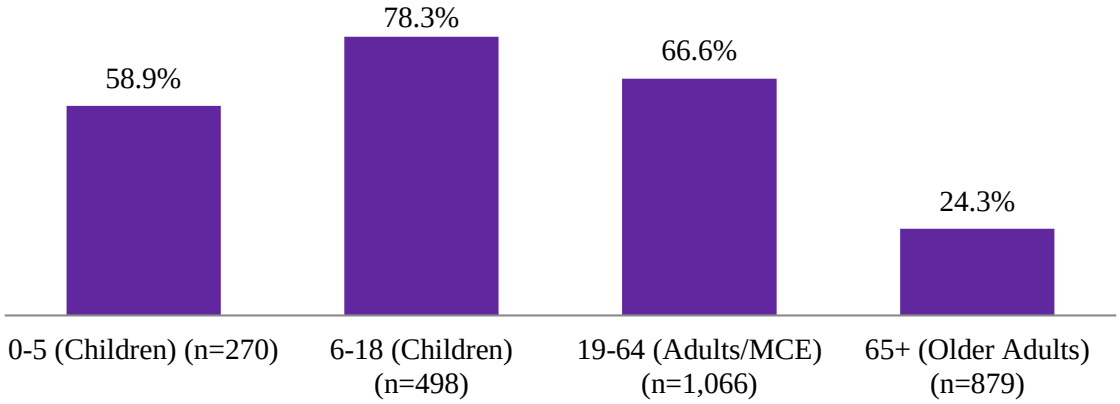
Type of public benefits that members receive[8]:

Receive CalFresh as a public benefit:

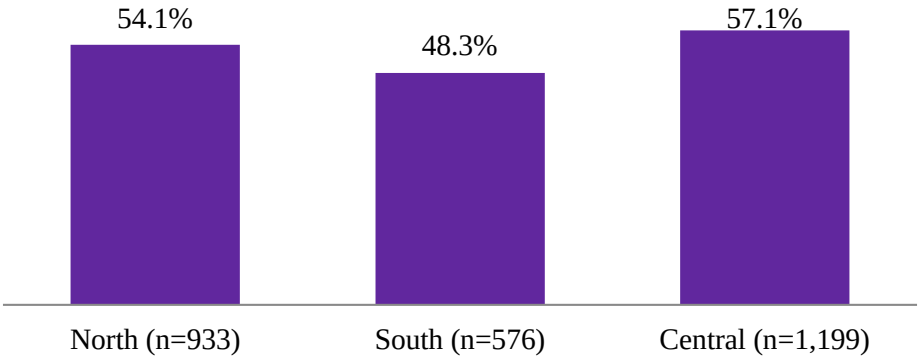
CalOptima language:



Age Category:



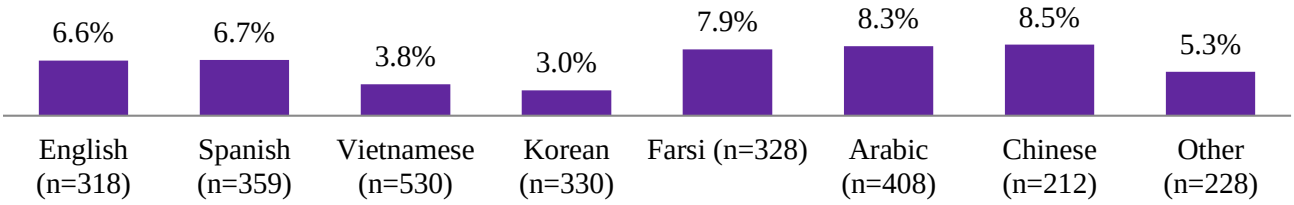
Region:



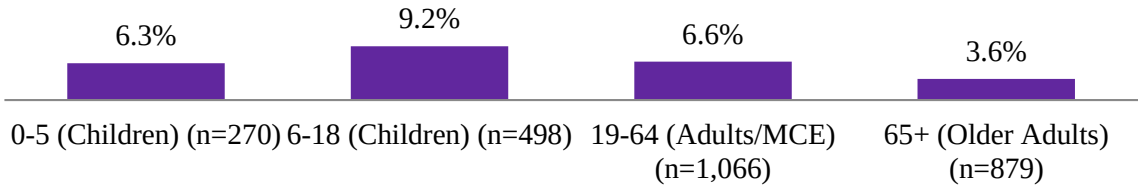
[8] Only reporting those who reported that they received at least one public benefit.

Receive TANF or CalWorks as a public benefit:

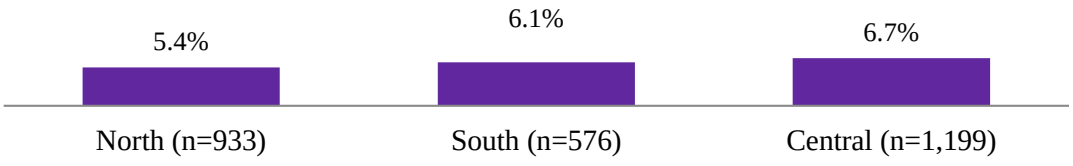
CalOptima language:



Age Category:

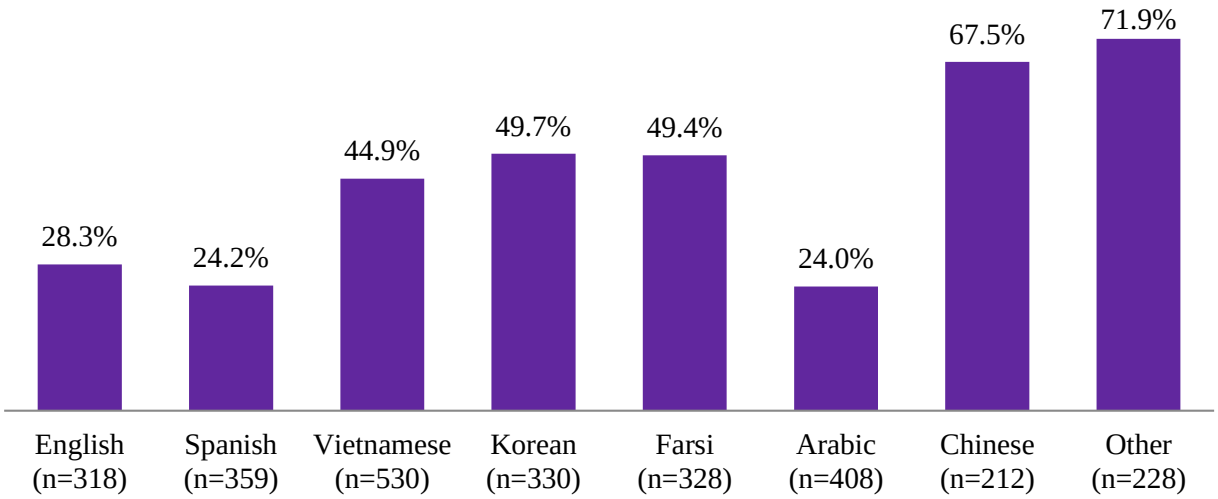


Region:

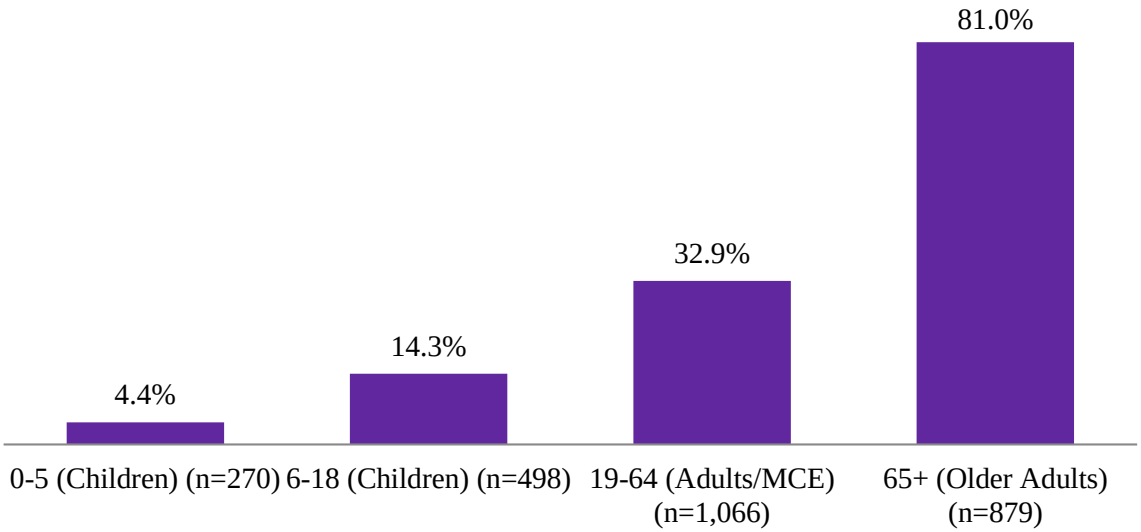


Receive SSI or SSDI as a public benefit:

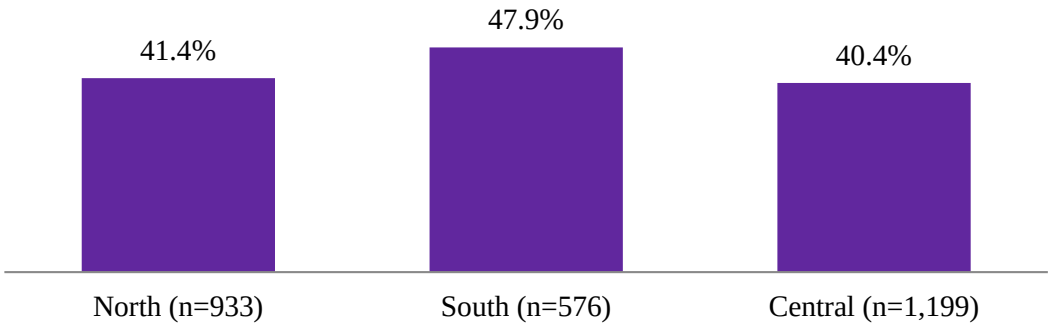
CalOptima language:



Age Category:

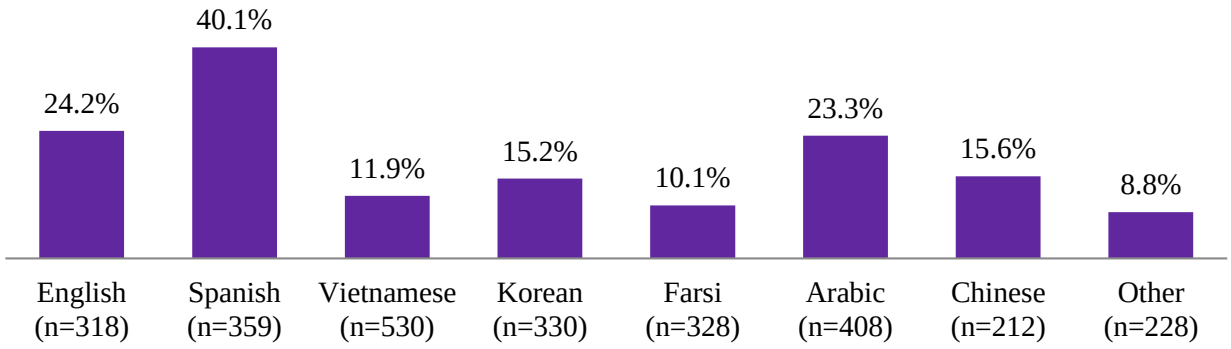


Region:

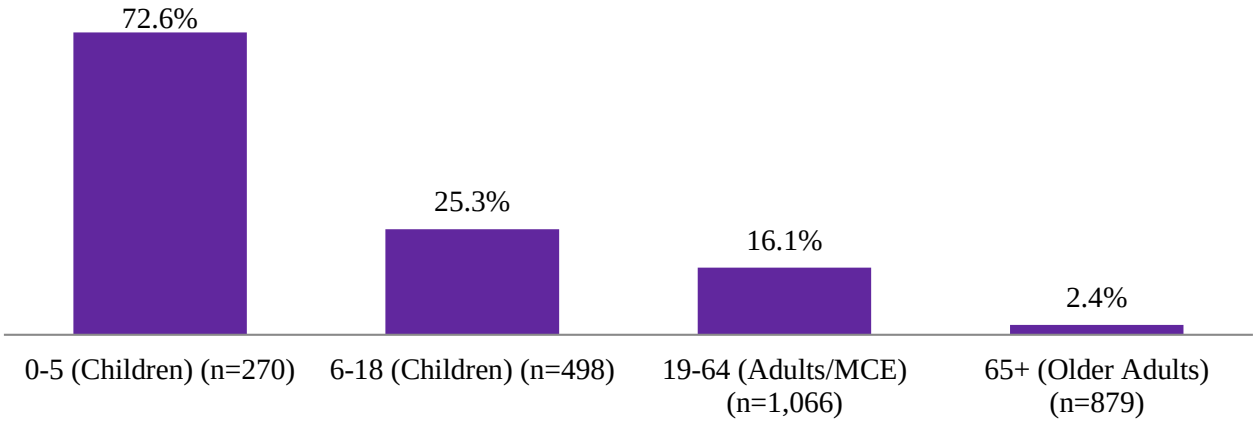


Receive WIC as a public benefit:

CalOptima language:



Age Category:



Region:

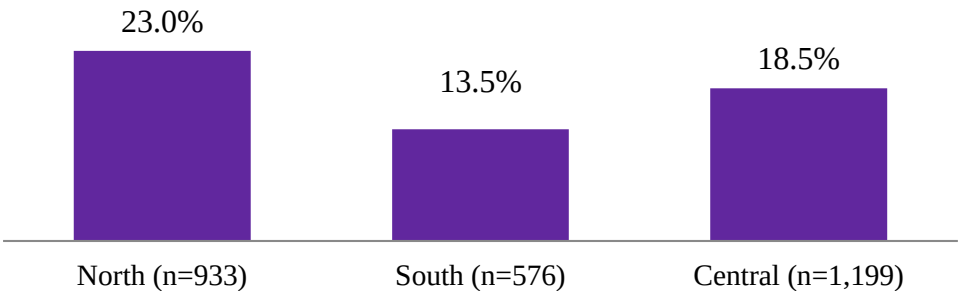


Exhibit 15. Personal activities participation:

CalOptima language:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	41.2%	6.4%	6.4%	45.9%	621
Spanish	19.1%	4.3%	3.1%	73.5%	607
Vietnamese	53.5%	3.3%	4.3%	38.9%	766
Korean	35.4%	6.3%	2.3%	56.0%	809
Farsi	28.5%	3.2%	3.4%	65.0%	537
Arabic	47.2%	5.9%	1.9%	45.0%	540
Chinese	16.8%	3.8%	3.1%	76.3%	583
Other	32.3%	4.0%	5.1%	58.6%	350
Do fun activities with others	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
English	63.3%	18.3%	7.4%	11.0%	635
Spanish	61.8%	13.0%	4.0%	21.2%	647
Vietnamese	49.6%	19.5%	9.3%	21.7%	789
Korean	51.9%	22.7%	7.3%	18.0%	859
Farsi	39.5%	25.0%	10.2%	**25.3%**	608
Arabic	54.8%	20.6%	6.7%	17.9%	586
Chinese	45.4%	12.1%	5.8%	**36.7%**	619
Other	46.3%	21.6%	11.6%	20.5%	361

Volunteer or charity	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	16.2%	15.8%	19.4%	48.6%	628
Spanish	15.9%	10.0%	9.9%	64.2%	628
Vietnamese	15.8%	19.1%	26.7%	38.3%	752
Korean	21.0%	13.2%	15.6%	50.2%	825
Farsi	15.4%	13.8%	19.9%	50.9%	578
Arabic	23.5%	18.1%	14.3%	44.2%	575
Chinese	16.5%	11.9%	14.0%	57.7%	607
Other	9.9%	7.0%	12.1%	71.0%	355

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	68.7%	11.5%	6.0%	13.7%	633
Spanish	66.0%	8.7%	2.8%	22.5%	644
Vietnamese	69.6%	6.6%	4.0%	19.8%	807
Korean	75.1%	10.1%	3.7%	11.2%	874
Farsi	68.9%	7.7%	5.6%	17.9%	627
Arabic	59.1%	11.8%	4.4%	24.7%	587
Chinese	71.9%	7.3%	3.8%	17.1%	661
Other	57.6%	10.2%	4.7%	27.5%	363

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	83.3%	6.0%	1.0%	9.6%	612
Spanish	85.1%	5.3%	1.0%	8.6%	590
Vietnamese	78.0%	5.1%	1.5%	15.4%	740
Korean	88.2%	6.3%	1.0%	4.5%	842
Farsi	84.3%	4.8%	1.9%	8.9%	516
Arabic	83.2%	5.5%	1.5%	9.8%	531
Chinese	86.9%	5.2%	1.1%	6.7%	610
Other	80.3%	6.7%	3.5%	9.5%	315

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	76.7%	12.2%	2.9%	8.2%	621
Spanish	80.1%	7.7%	2.9%	9.3%	613
Vietnamese	78.2%	7.7%	1.9%	12.1%	725
Korean	73.6%	13.8%	4.6%	8.0%	864
Farsi	78.4%	9.9%	3.7%	8.0%	538
Arabic	74.5%	11.4%	2.7%	11.4%	553
Chinese	85.9%	5.3%	2.4%	6.3%	618
Other	82.9%	9.2%	3.5%	4.4%	315

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	0.8%	1.1%	6.2%	91.9%	632
Spanish	0.2%	0.3%	2.5%	97.1%	651
Vietnamese	2.6%	0.6%	3.1%	93.7%	772
Korean	0.8%	0.8%	6.5%	91.8%	846
Farsi	1.3%	1.0%	2.9%	94.8%	594
Arabic	5.0%	2.4%	1.0%	91.6%	582
Chinese	7.5%	2.3%	3.3%	86.8%	598
Other	2.2%	2.0%	8.1%	87.7%	358

Age Category:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	32.2%	3.4%	2.0%	62.4%	348
6-18 (Children)	33.0%	3.9%	2.5%	60.6%	1,077
19-64 (Adults/MCE)	43.2%	5.6%	4.2%	47.0%	2,093
65+ (Older Adults)	24.3%	4.3%	4.2%	67.2%	1,295

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	75.0%	9.8%	2.9%	12.2%	376
6-18 (Children)	72.5%	12.3%	4.7%	10.6%	1,137
19-64 (Adults/MCE)	43.6%	24.2%	9.3%	23.0%	2,190
65+ (Older Adults)	41.9%	19.2%	8.6%	30.3%	1,401

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	14.5%	10.4%	11.0%	64.1%	365
6-18 (Children)	22.7%	18.3%	17.2%	41.8%	1,117
19-64 (Adults/MCE)	18.0%	14.9%	20.8%	46.3%	2,142
65+ (Older Adults)	12.1%	10.1%	12.2%	65.6%	1,324

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	69.2%	7.0%	1.9%	21.9%	370
6-18 (Children)	77.9%	8.4%	3.2%	10.5%	1,148
19-64 (Adults/MCE)	62.2%	12.6%	5.7%	19.5%	2,211
65+ (Older Adults)	69.3%	4.9%	3.6%	22.2%	1,467

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	89.8%	3.6%	0.6%	6.1%	362
6-18 (Children)	90.2%	4.5%	0.9%	4.3%	1,084
19-64 (Adults/MCE)	80.5%	6.7%	1.7%	11.0%	2,061
65+ (Older Adults)	82.4%	5.2%	1.6%	10.8%	1,249

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	79.0%	6.4%	3.6%	11.0%	362
6-18 (Children)	83.2%	7.7%	2.4%	6.7%	1,110
19-64 (Adults/MCE)	70.7%	14.3%	4.3%	10.8%	2,105
65+ (Older Adults)	86.5%	5.3%	1.7%	6.5%	1,270

Visit a casino or gamble on the internet	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	3.0%	0.5%	1.6%	94.8%	368
6-18 (Children)	2.3%	0.6%	1.8%	95.3%	1,134
19-64 (Adults/MCE)	1.9%	1.0%	5.4%	91.7%	2,171
65+ (Older Adults)	3.2%	2.3%	4.6%	89.9%	1,360

Region:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	35.3%	5.4%	3.7%	55.6%	1,639
South	28.8%	4.2%	4.0%	62.9%	1,252
Central	38.8%	4.4%	3.4%	53.4%	1,910

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	51.8%	20.1%	8.0%	20.0%	1,757
South	47.7%	21.1%	8.0%	23.2%	1,345
Central	55.0%	16.6%	6.9%	21.5%	1,989

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	17.7%	13.8%	16.0%	52.5%	1,702
South	16.8%	13.2%	16.8%	53.3%	1,307
Central	17.1%	14.9%	17.9%	50.1%	1,927

Physical fitness	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	67.4%	10.2%	4.9%	17.5%	1,780
South	69.4%	8.8%	4.4%	17.4%	1,387
Central	67.9%	8.3%	3.7%	20.1%	2,017

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	86.8%	4.7%	0.8%	7.7%	1,668
South	86.0%	5.3%	1.8%	6.9%	1,230
Central	79.9%	6.6%	1.7%	11.8%	1,848

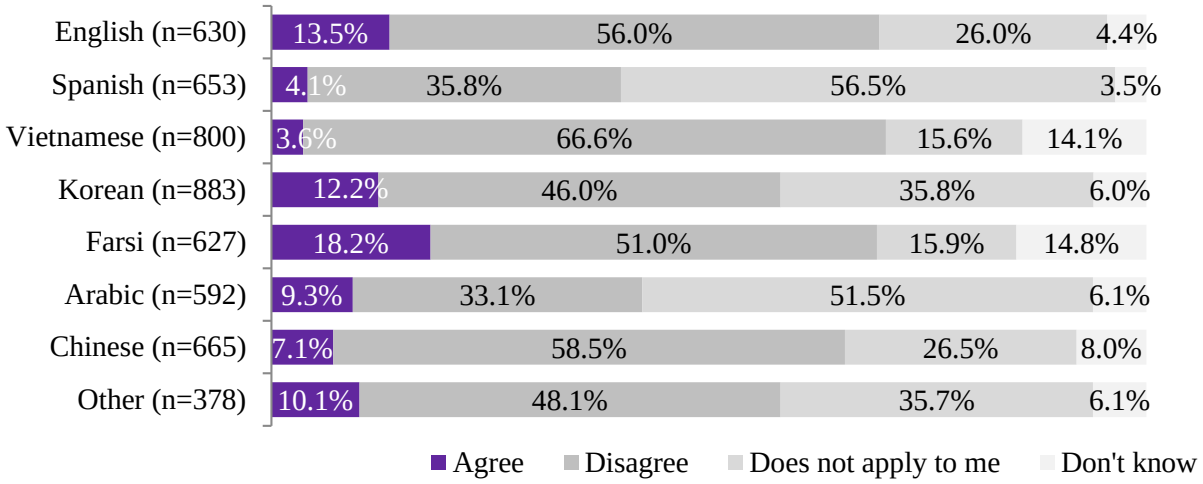
Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	76.2%	10.9%	3.8%	9.1%	1,694
South	81.0%	9.2%	3.3%	6.5%	1,263
Central	78.5%	9.2%	2.3%	9.9%	1,880

Visit a casino or gamble on the internet	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	1.5%	0.9%	4.5%	93.2%	1,726
South	4.0%	1.1%	3.7%	91.3%	1,327
Central	2.2%	1.7%	4.0%	92.1%	1,969

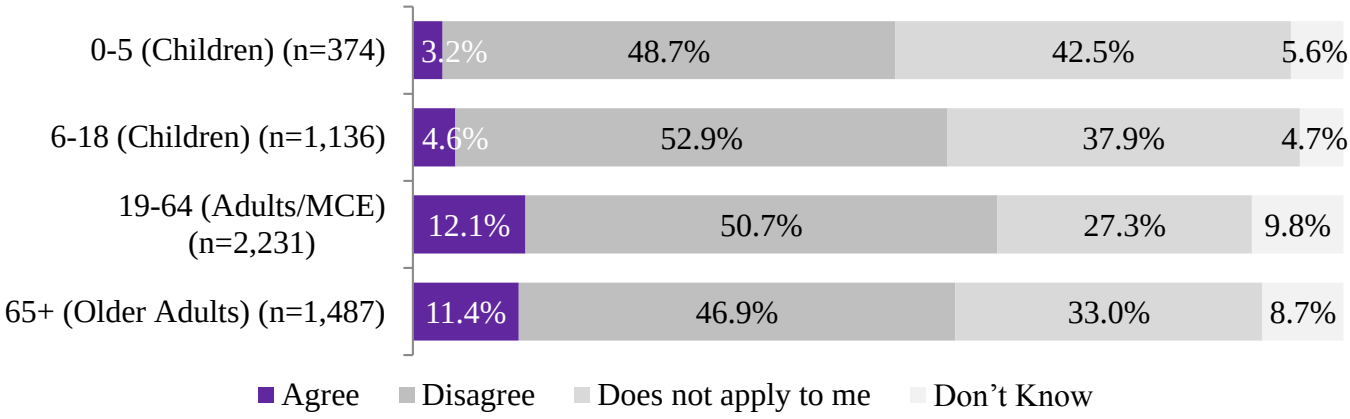
Exhibit 16. Feelings towards community and home enviroment:

Feeling lonely and isolated:

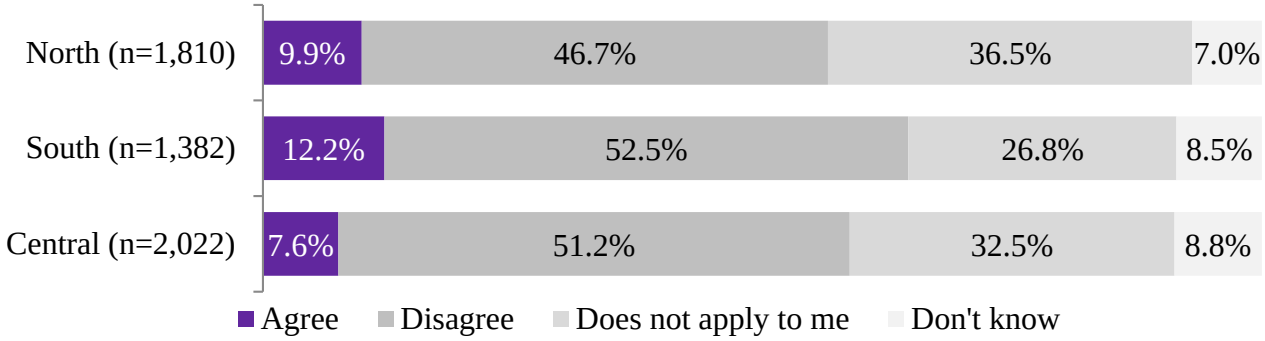
CalOptima language:



Age Category:

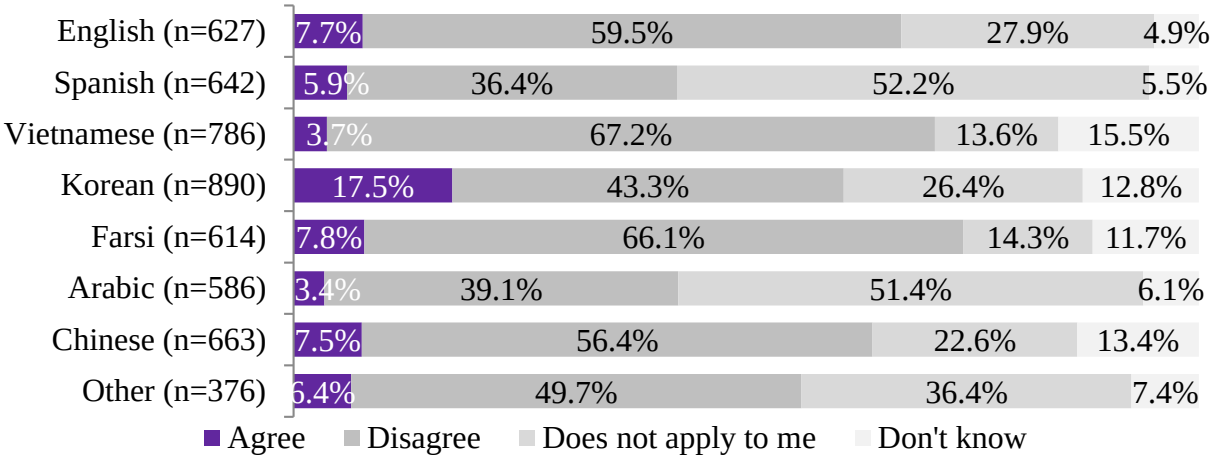


Region:

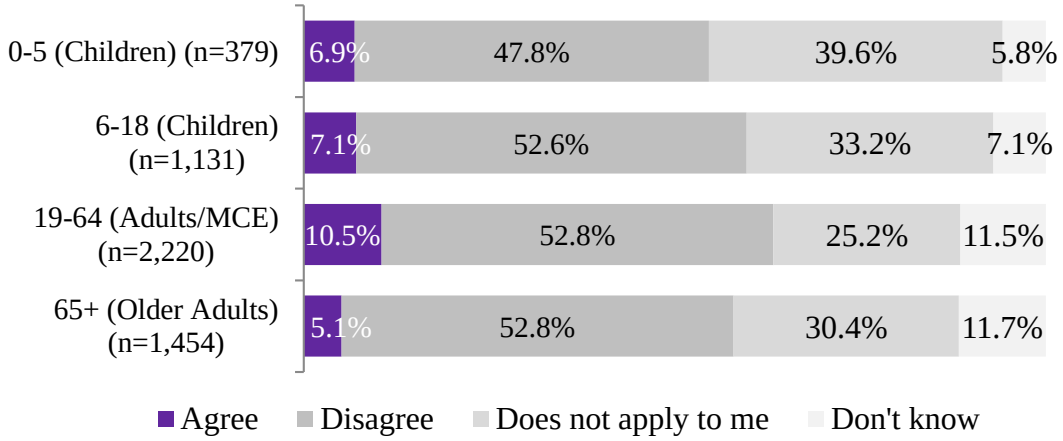


Feel not treated equally because of ethnic and culutral backgrounds:

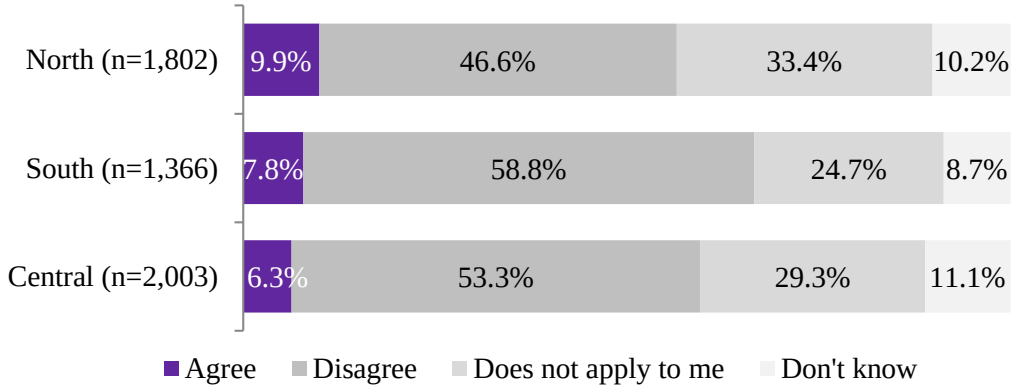
CalOptima language:



Age Category:

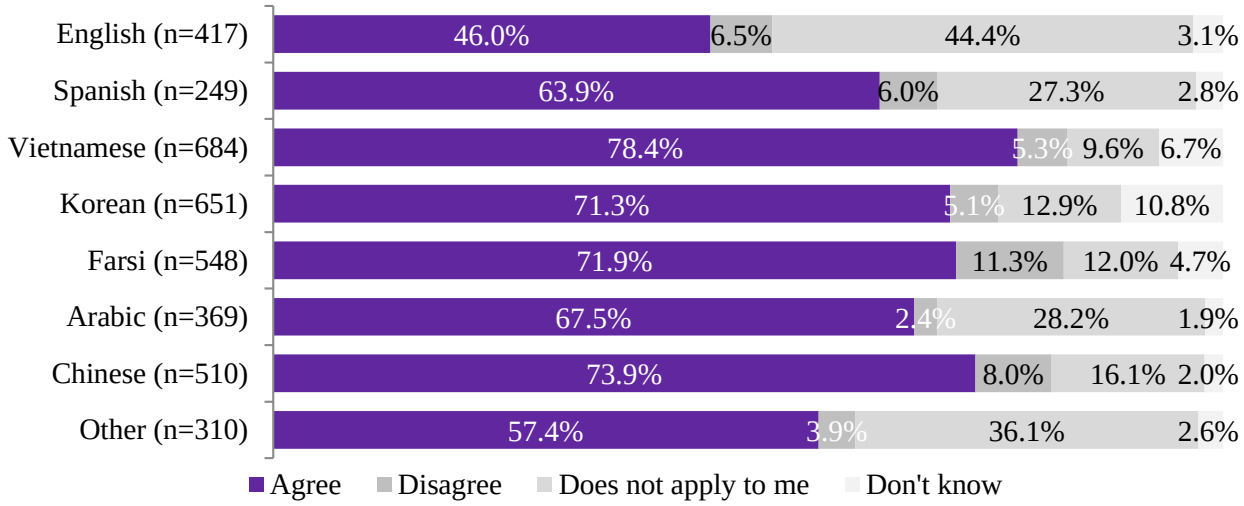


Region:



Feel child respects them as a parent[9]:

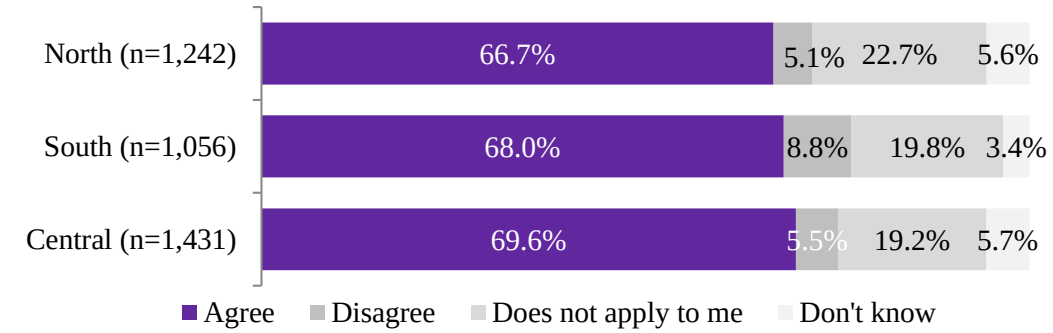
CalOptima language:



Age Category:



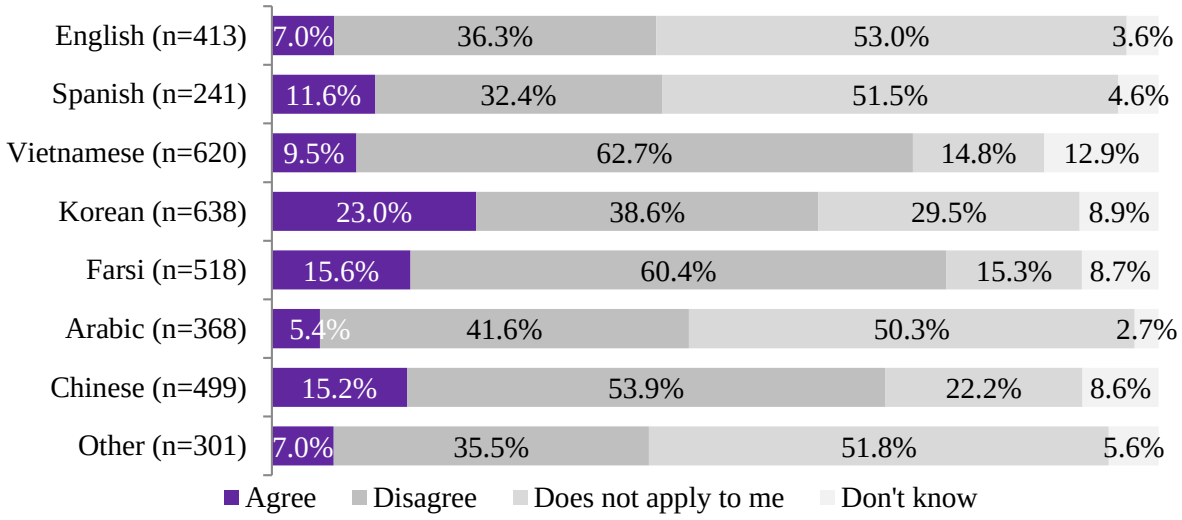
Region:



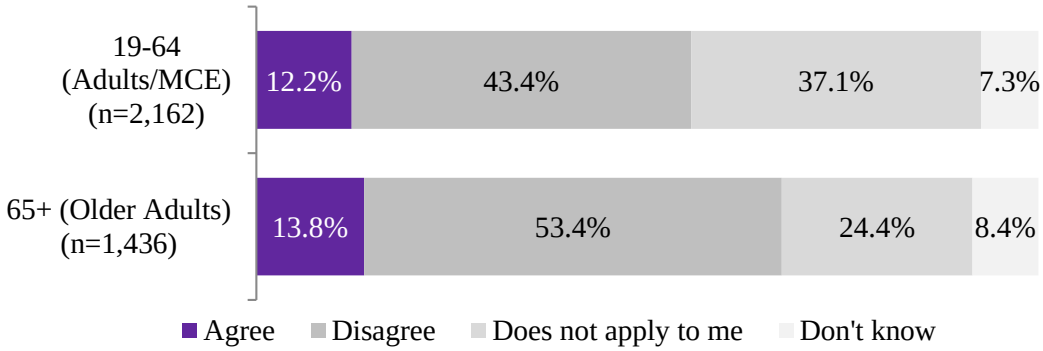
[9] Only reported those who are over 18 years old.

Feel child's attitudes and behavior conflict with cultural values[10]:

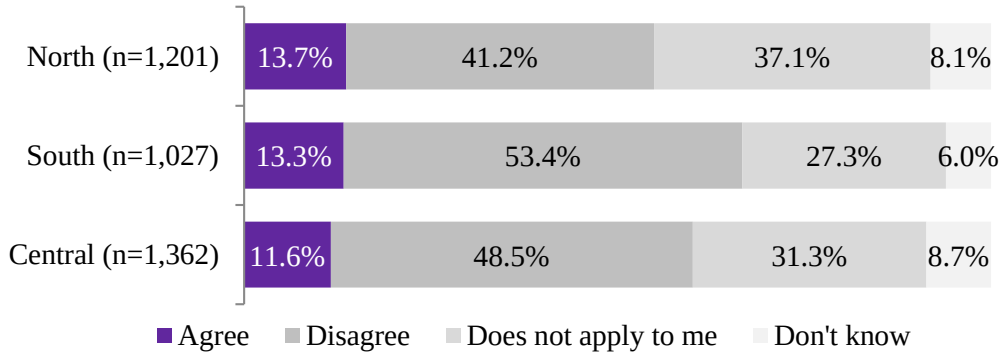
CalOptima language:



Age Category:



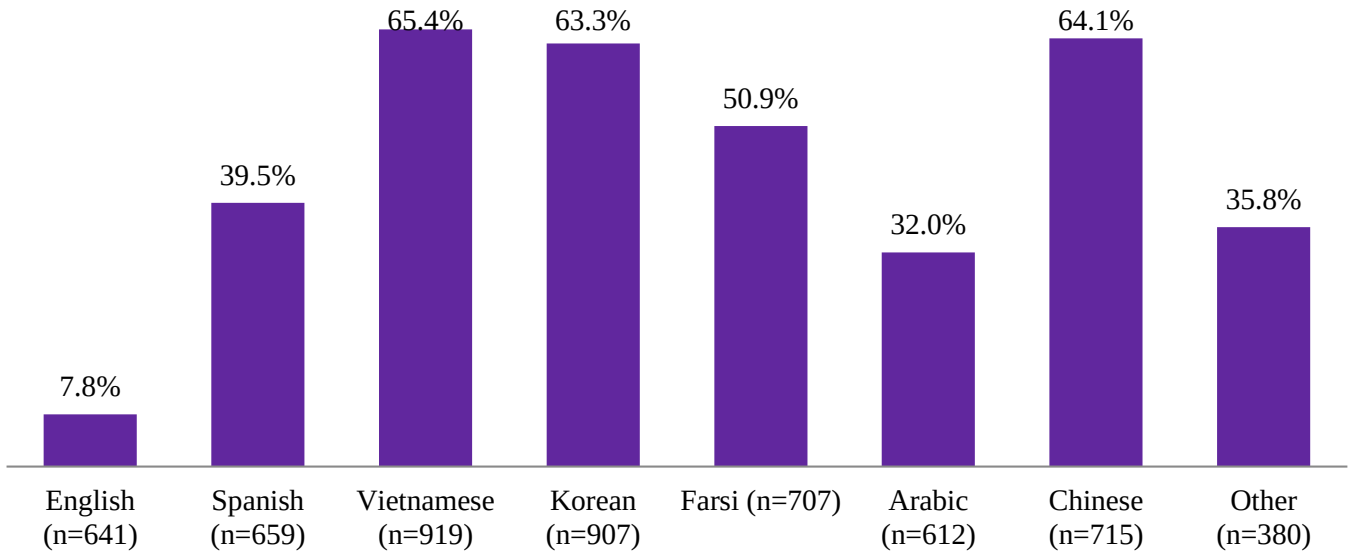
Region:



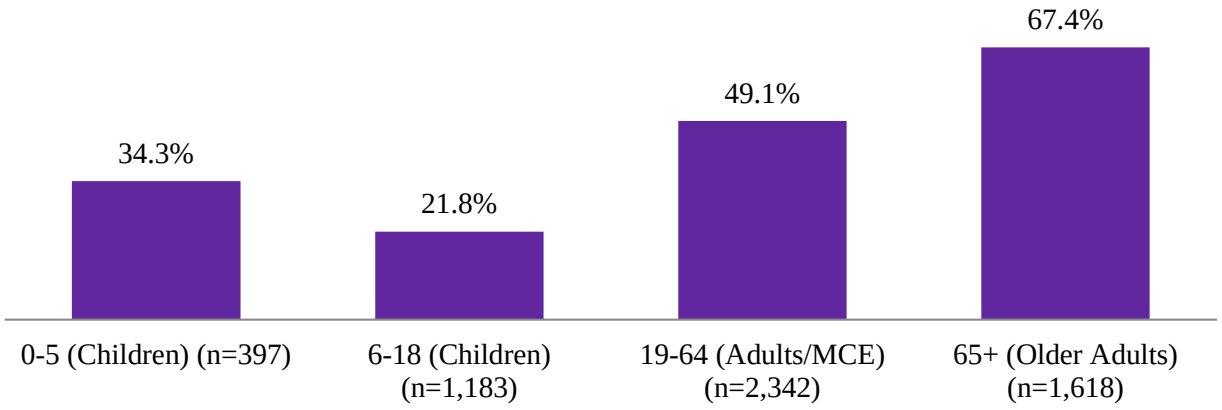
[10] Only reported those who are over 18 years old.

Exhibit 17. Members who reported that they speak English "not well":

CalOptima language:



Age Category:



Region:

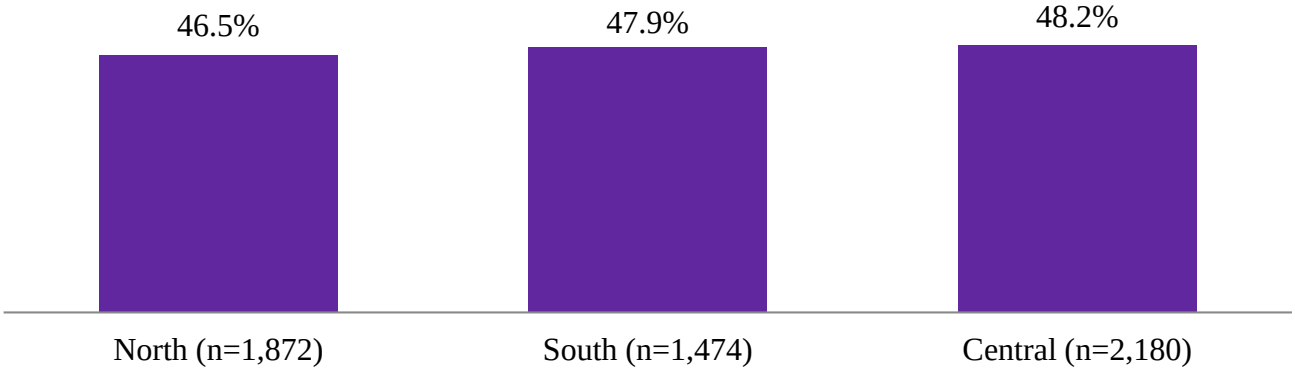


Exhibit 18. Employment status[11,12]

CalOptima language:

CalOptima language	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
English	36.7%	9.8%	7.2%	9.4%	13.4%	15.8%	20.4%	417
Spanish	21.7%	7.8%	11.6%	4.7%	21.3%	17.1%	28.3%	258
Vietnamese	32.1%	1.8%	12.1%	6.6%	24.4%	17.0%	20.0%	761
Korean	18.2%	11.6%	21.3%	6.9%	24.5%	10.0%	16.5%	638
Farsi	18.0%	4.4%	15.3%	7.6%	19.5%	26.5%	29.9%	616
Arabic	25.5%	4.2%	21.1%	9.4%	15.7%	11.9%	22.0%	427
Chinese	14.0%	3.8%	14.2%	4.9%	45.0%	6.8%	19.5%	529
Other	15.7%	3.4%	8.9%	3.7%	37.5%	10.2%	30.8%	325

Age Category:

Age Category	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
19-64 (Adults/MCE)	35.8%	8.3%	17.5%	10.9%	5.9%	17.6%	15.3%	2,370
65+ (Older Adults)	4.1%	1.7%	10.1%	0.7%	53.7%	10.5%	33.3%	1,601

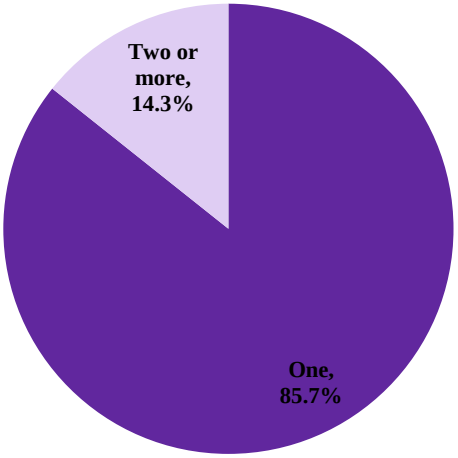
Region:

Region	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
North	24.0%	6.7%	15.9%	6.7%	23.6%	12.7%	22.5%	1,269
South	17.3%	6.6%	16.7%	7.3%	26.6%	17.3%	22.1%	1,129
Central	26.1%	4.0%	11.7%	6.5%	25.6%	14.7%	23.2%	1,561

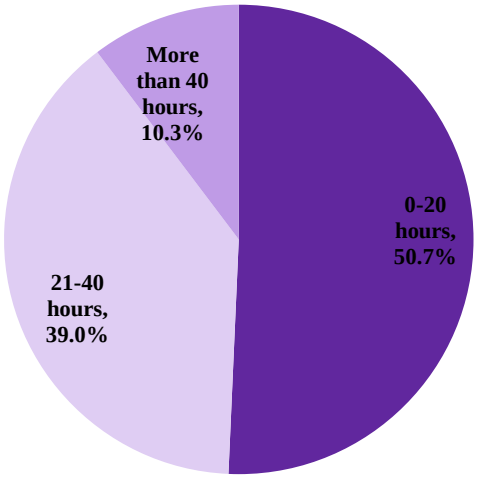
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]

Number of jobs members have

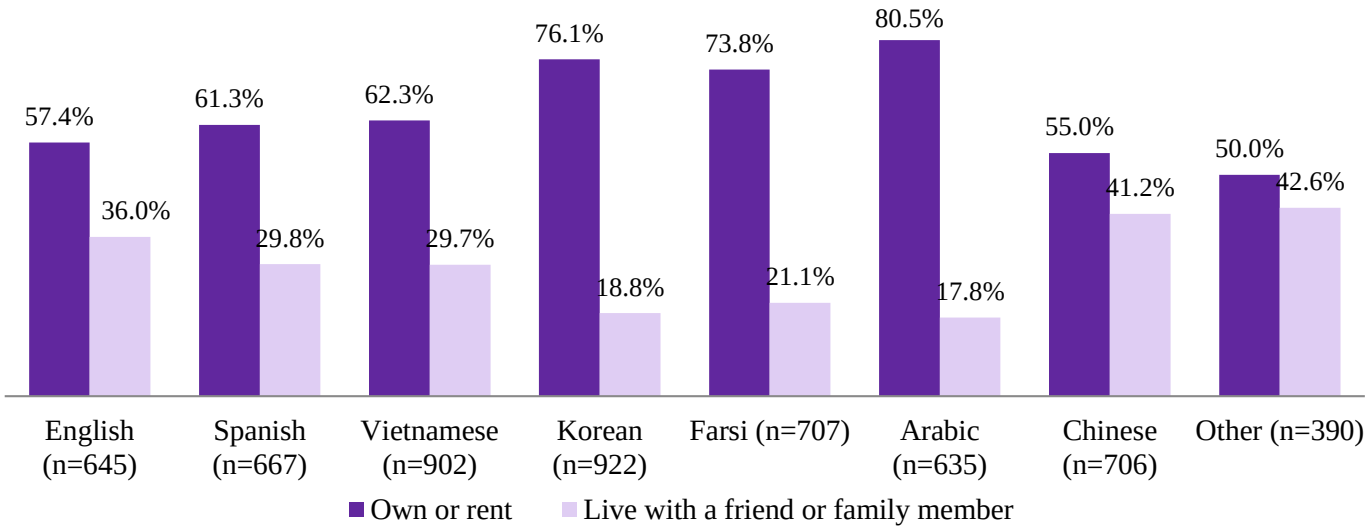


Number of hours that members work each week

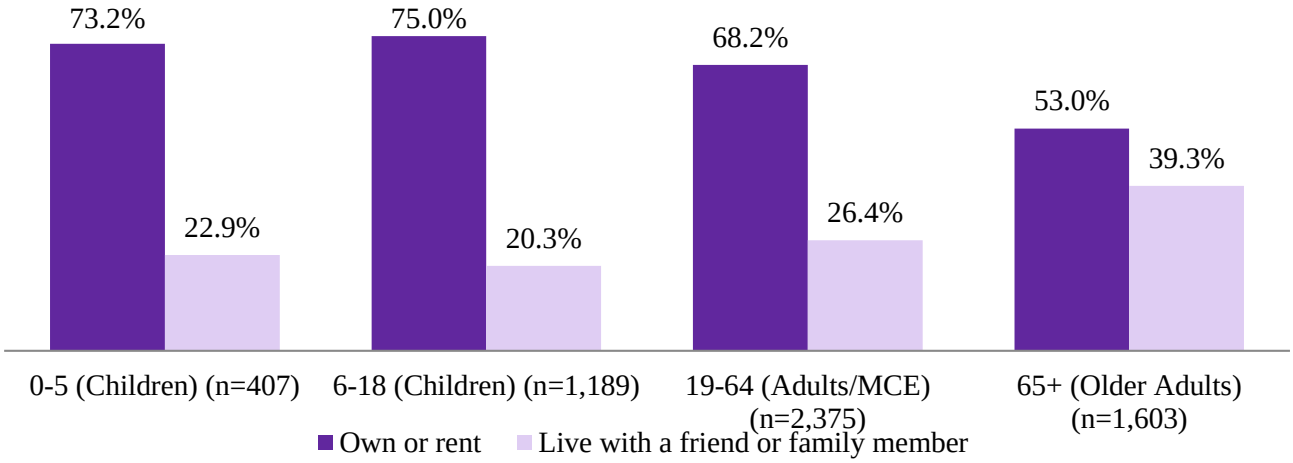


[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

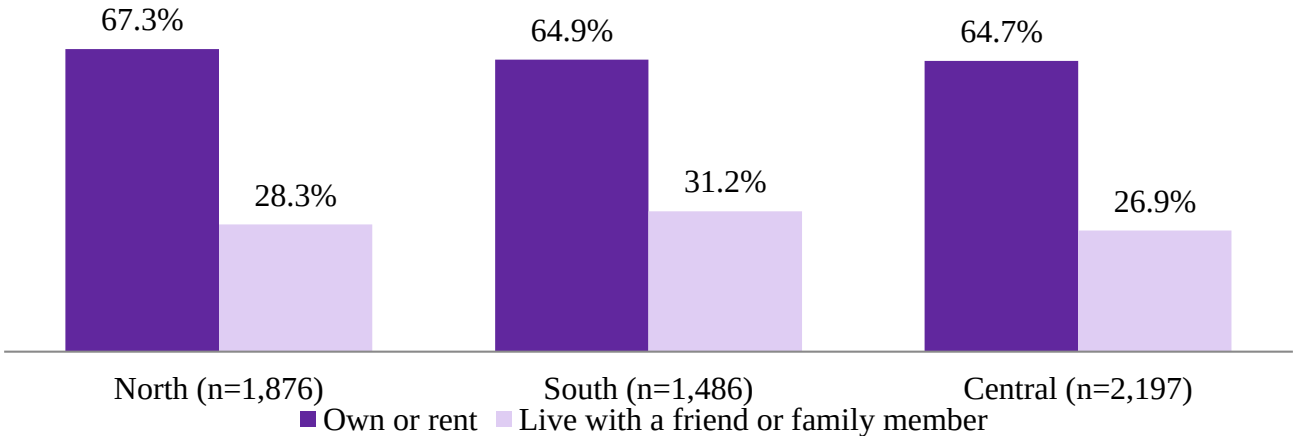
Exhibit 20. Members' living situation[14]



Age Category:



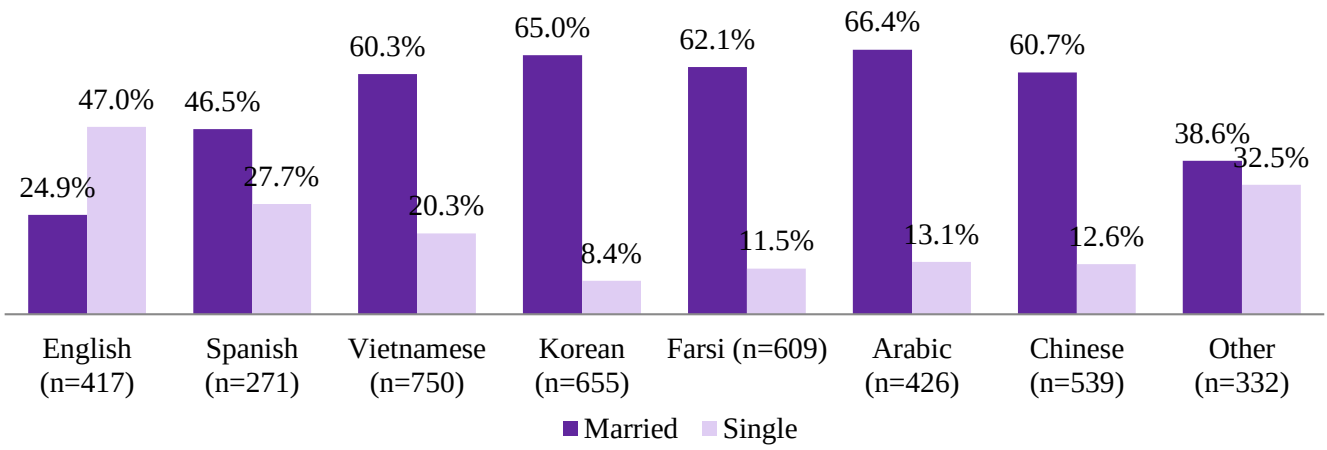
Region:



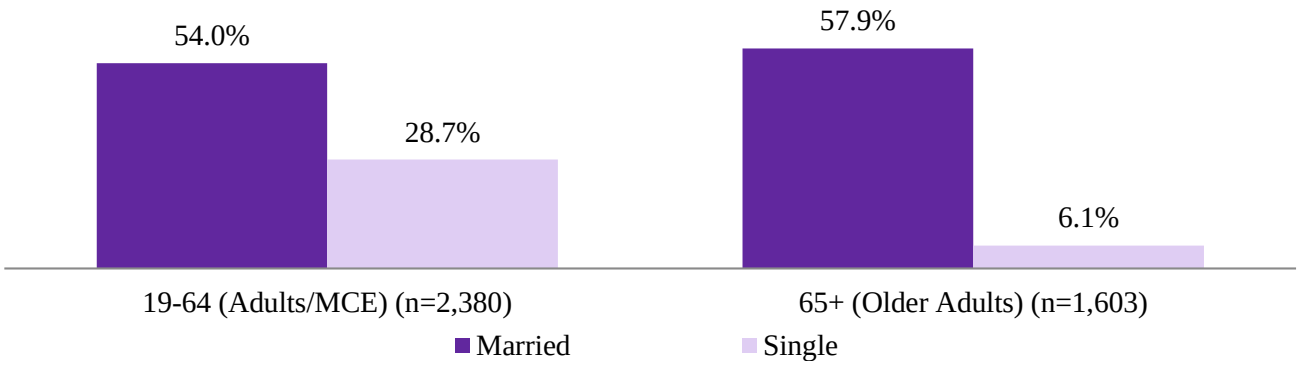
[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

Exhibit 21. Marital status of members[15],[16]

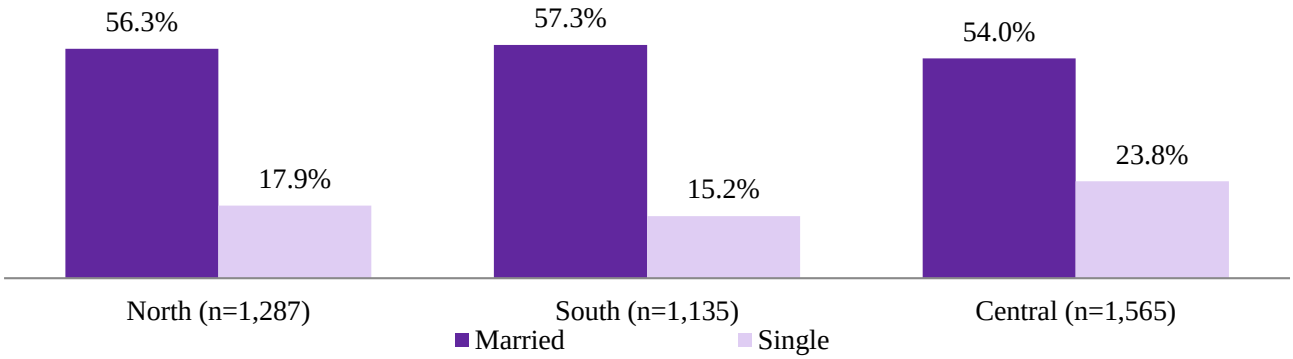
CalOptima language:



Age Category:



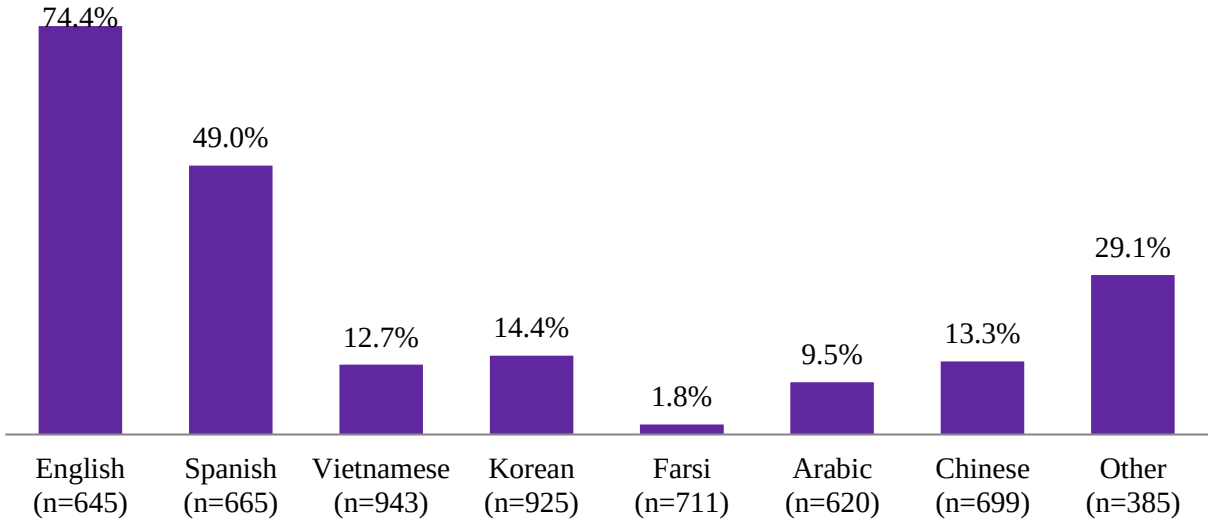
Region:



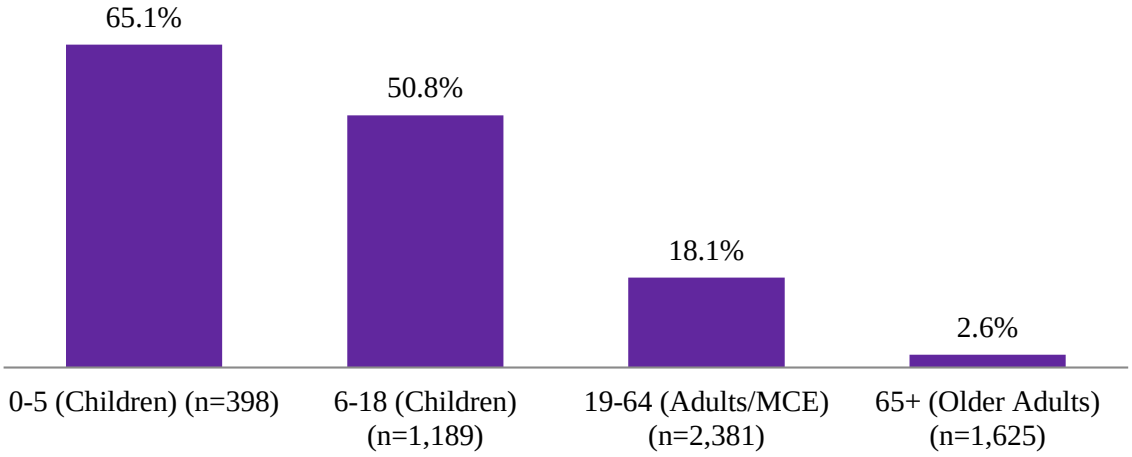
[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

Exhibit 22. Percent of members who were born in the United States:

CalOptima language:



Age Category:



Region:

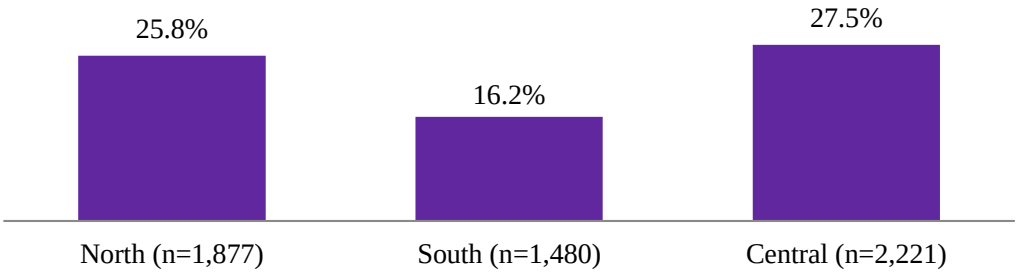
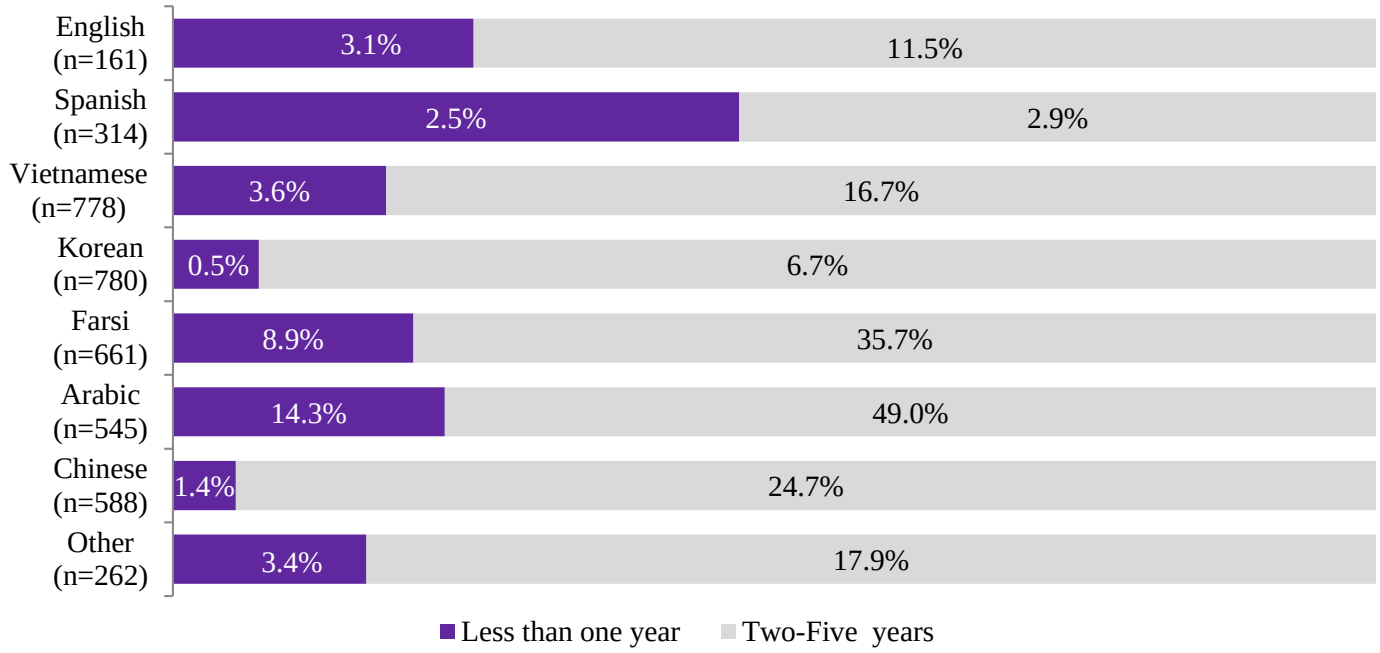
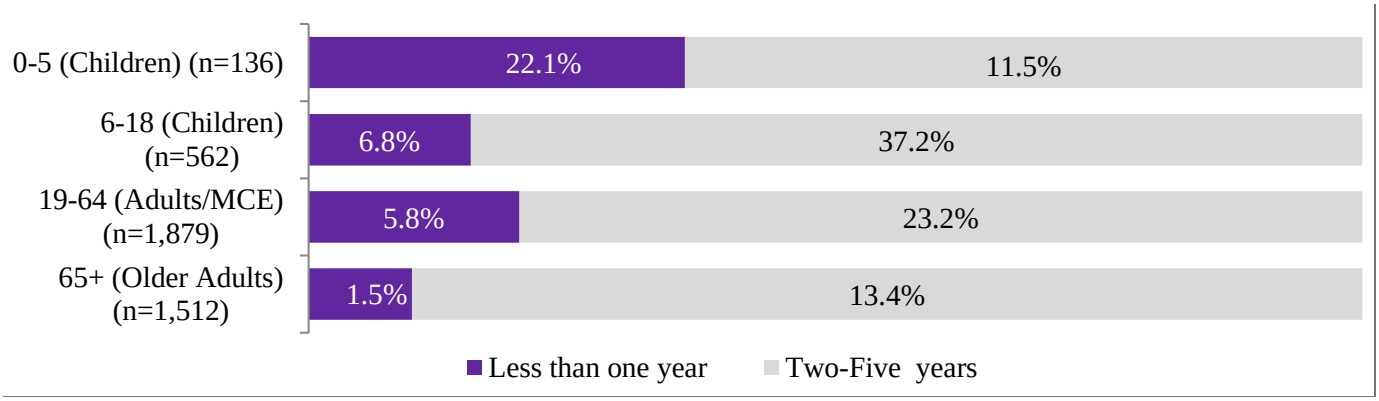


Exhibit 23. Length of time lived in the United States of those not born in the United States

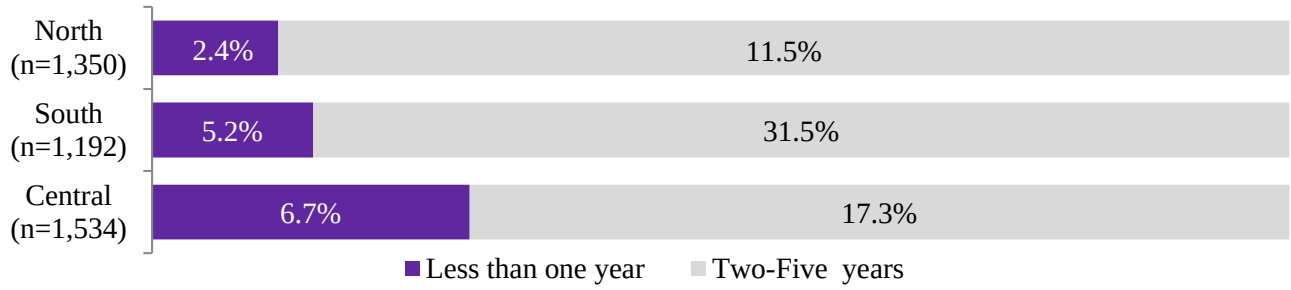
CalOptima language:



Age Category:



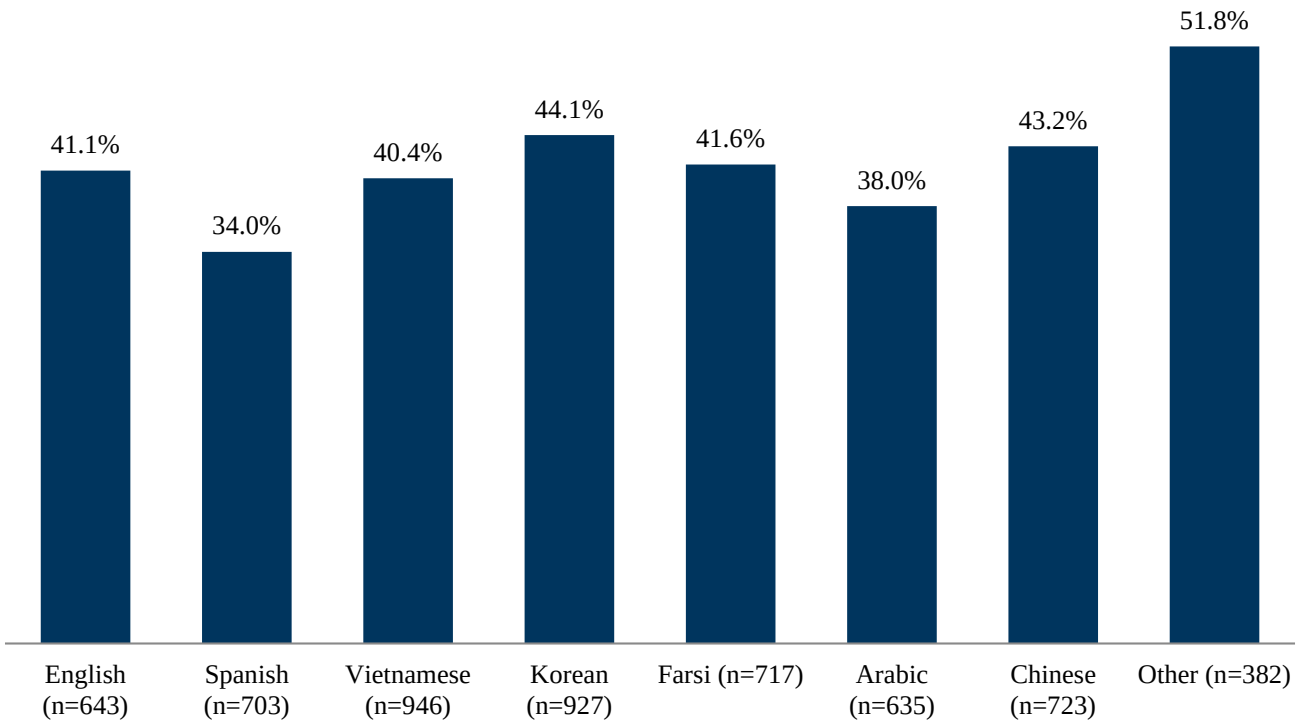
Region:



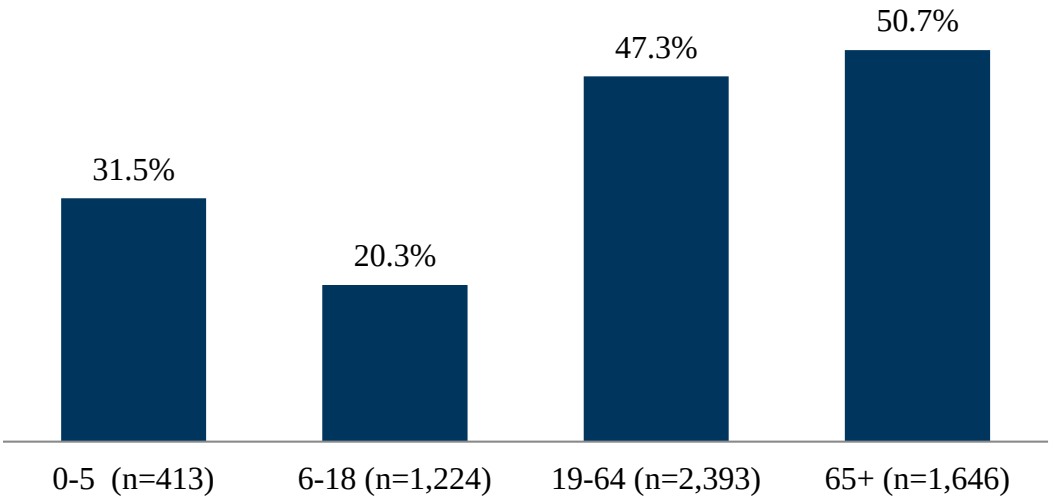
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:



Age Category:



Region:

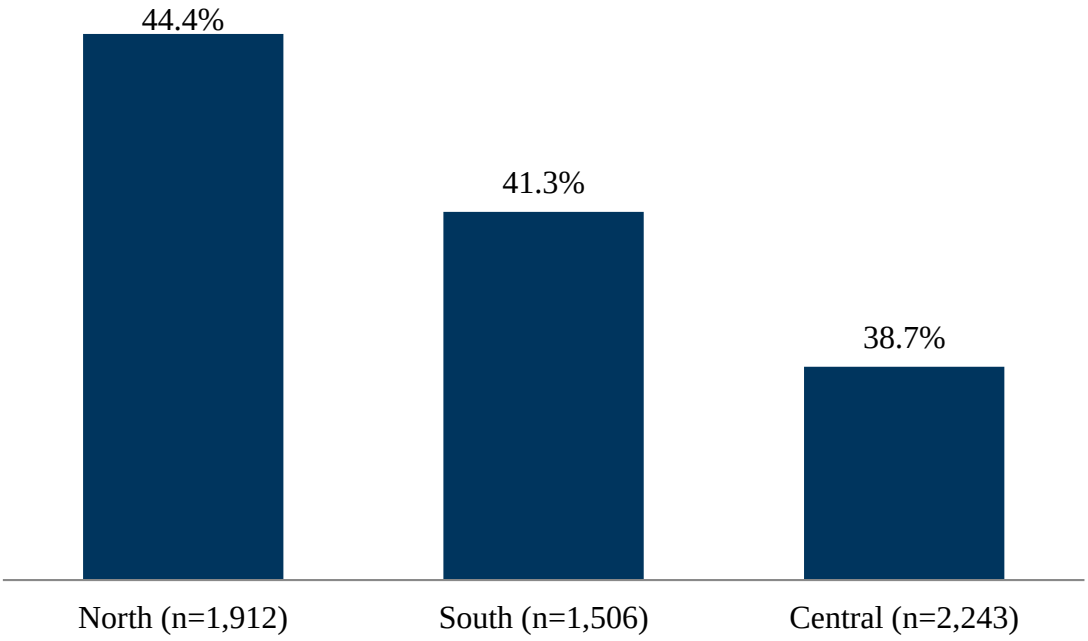


Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]

CalOptima Language:

CalOptima Language	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
English	43.8%	28.3%	6.6%	8.1%	258
Spanish	39.5%	17.6%	4.9%	12.2%	205
Vietnamese	26.6%	15.7%	5.0%	13.0%	338
Korean	64.2%	35.3%	4.1%	5.1%	391
Farsi	53.1%	23.8%	5.1%	8.1%	273
Arabic	62.9%	16.3%	1.8%	11.8%	221
Chinese	40.6%	21.1%	7.7%	14.1%	298
Other	33.1%	23.2%	5.5%	12.7%	181

Age Category:

CalOptima Age Category	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
0-5 (Children)	19.5%	23.7%	3.4%	14.4%	118
6-18 (Children)	34.7%	25.6%	1.8%	15.1%	219
19-64 (Adults/MCE)	52.7%	27.3%	4.1%	9.0%	1,062
65+ (Older Adults)	19.5%	23.7%	3.4%	14.4%	766

[17] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

[18] Only reported those who have not seen a dentist within the past 12 months.

Region:

CalOptima Region	Cost	Don't have/know dentist	No transportation	Don't know	n
	%	%	%	%	
North	48.9%	22.3%	5.5%	9.9%	798
South	51.6%	28.2%	4.6%	9.4%	585
Central	39.2%	20.9%	5.2%	11.3%	776

Exhibit 26. Days per week member had at least one drink of alcoholic beverage during the past 30 days [19]

CalOptima language:

CalOptima Language	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
English	71.7%	19.6%	4.0%	2.0%	2.7%	403
Spanish	83.5%	10.4%	1.3%	0.9%	3.9%	230
Vietnamese	81.3%	10.7%	1.9%	1.8%	4.3%	738
Korean	77.1%	15.5%	3.0%	1.5%	2.9%	593
Farsi	74.8%	19.3%	1.2%	0.2%	4.4%	497
Arabic	87.6%	4.5%	0.6%	0.8%	6.5%	355
Chinese	84.9%	8.0%	1.2%	0.6%	5.4%	503
Other	83.7%	7.7%	1.6%	1.3%	5.8%	312

Age Category:

CalOptima Age Category	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
19-64 (Adults/MCE)	78.7%	13.0%	2.3%	1.0%	4.9%	2,163
65+ (Older Adults)	82.2%	11.4%	1.4%	1.4%	3.5%	1,468

[19] Only reported those who are 18 years or older.

Region:

CalOptima Region	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
North	81.1%	11.9%	1.2%	1.5%	4.3%	1,156
South	79.5%	14.5%	1.8%	0.7%	3.5%	1,000
Central	79.7%	11.4%	2.5%	1.3%	5.1%	1,465

January 2018

CalOptima Member Survey Data Book:

Weighted Population Estimates

harder + co | community research

CalOptima A Public Agency Better. Together.

Navigating the Healthcare System

Exhibit 27. Percent who report at least one person as their doctor (n=5,749)

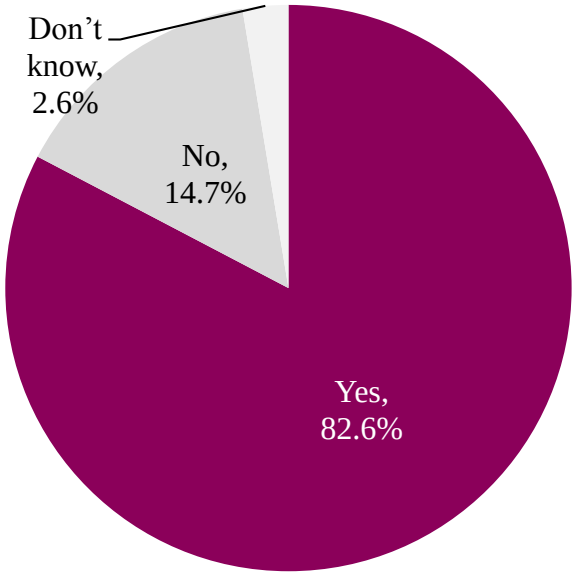


Exhibit 28. Where respondents go to see their doctor (n=5,743)

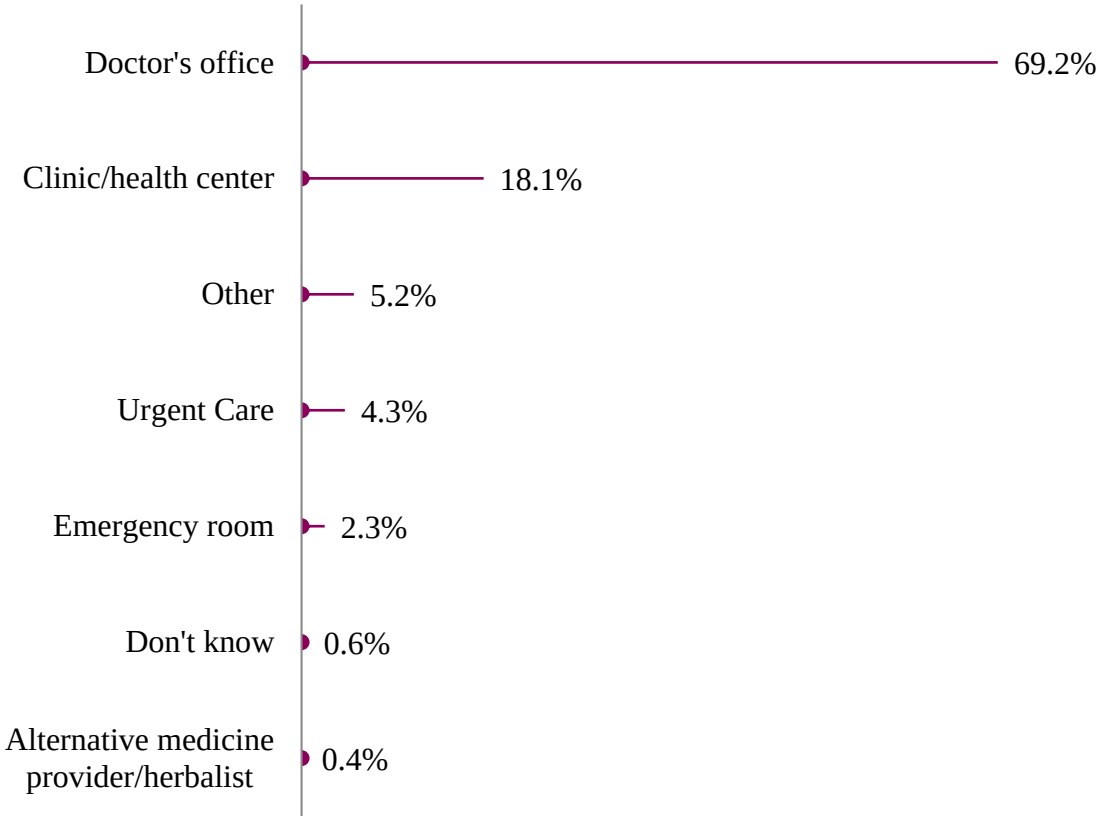


Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

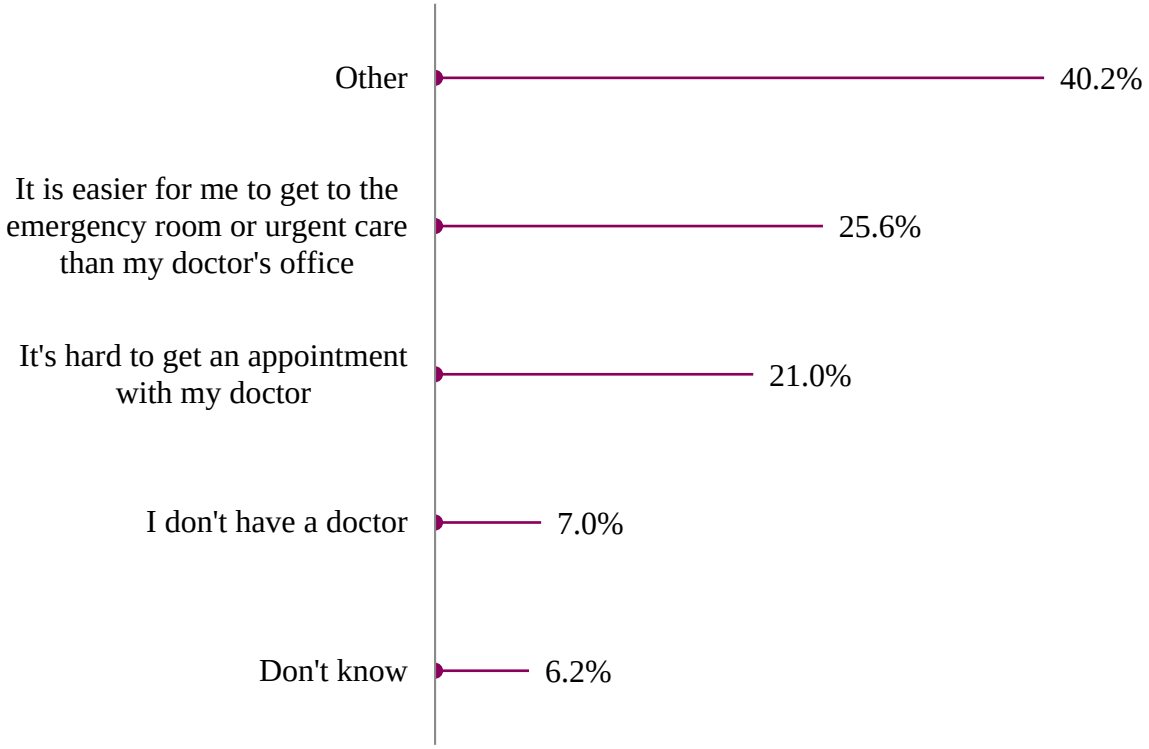


Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]

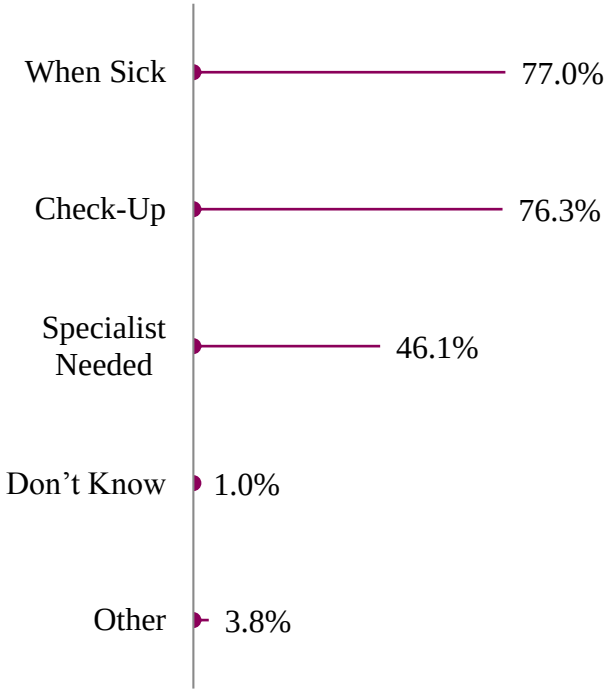
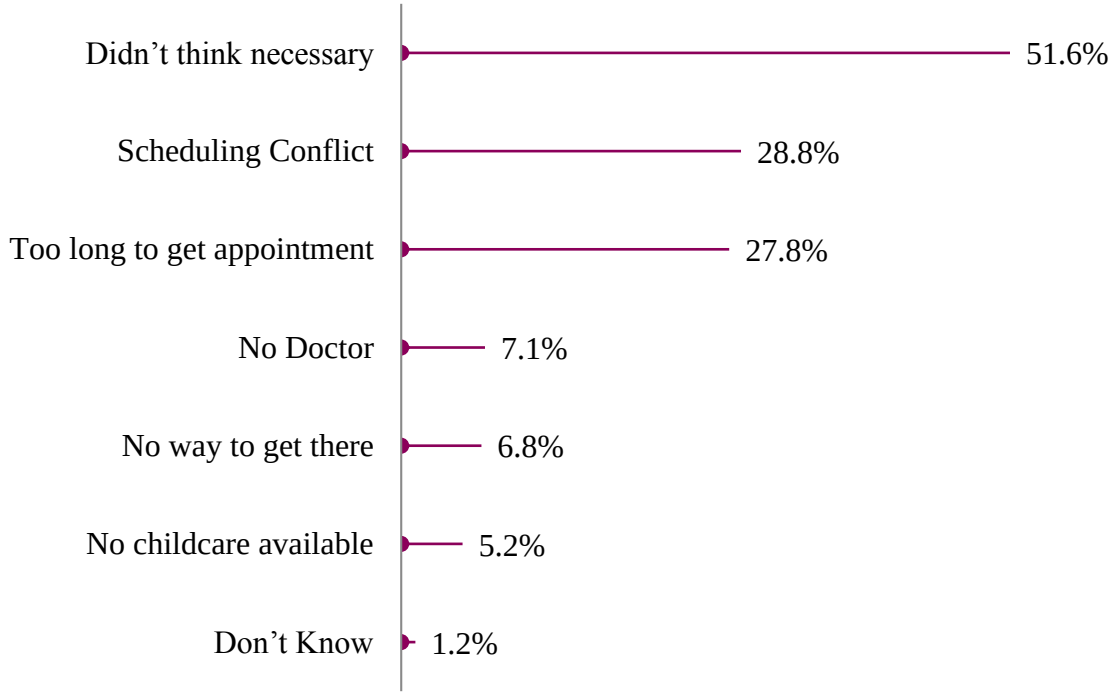


Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]



[20] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[21] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 32. When do members make an appointment to see a specialist (n=5,590)[22]

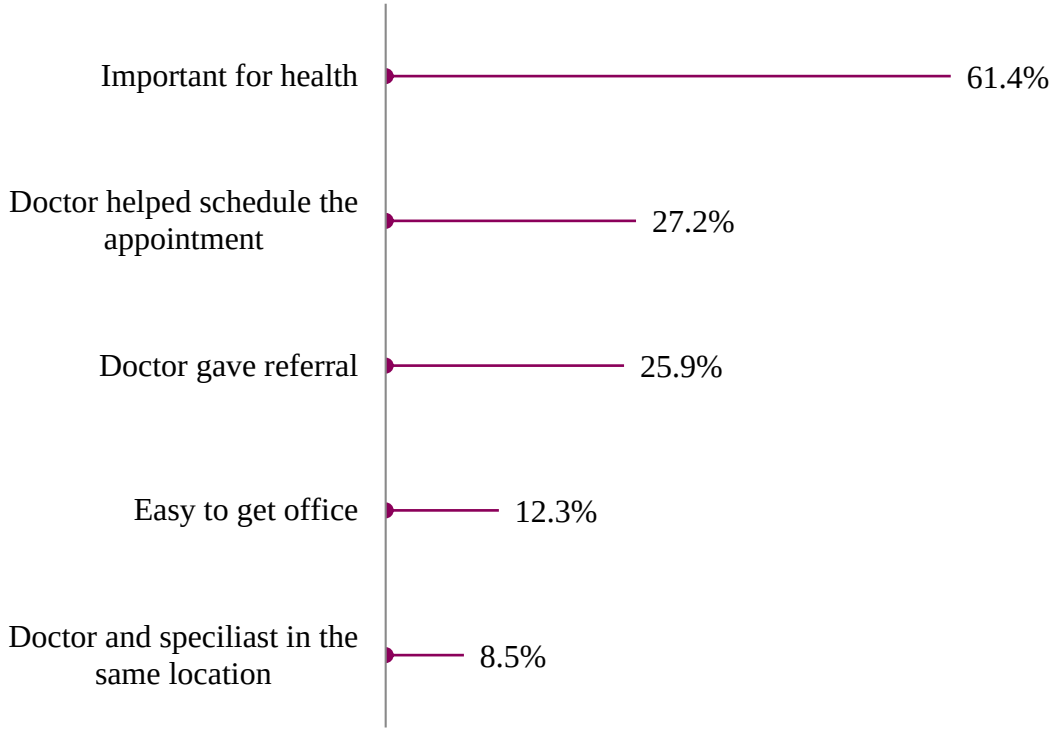
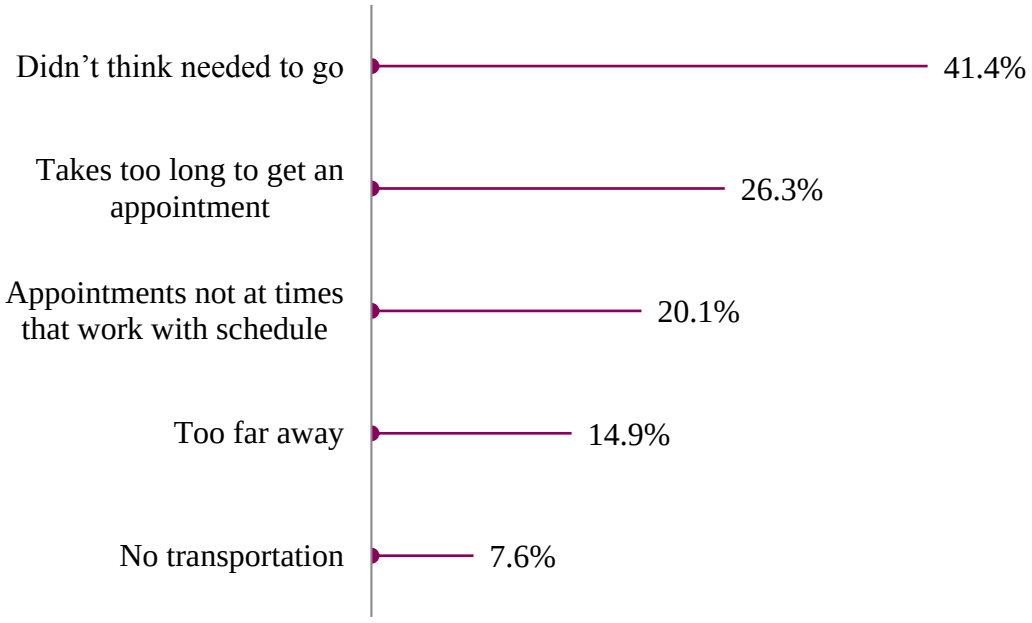
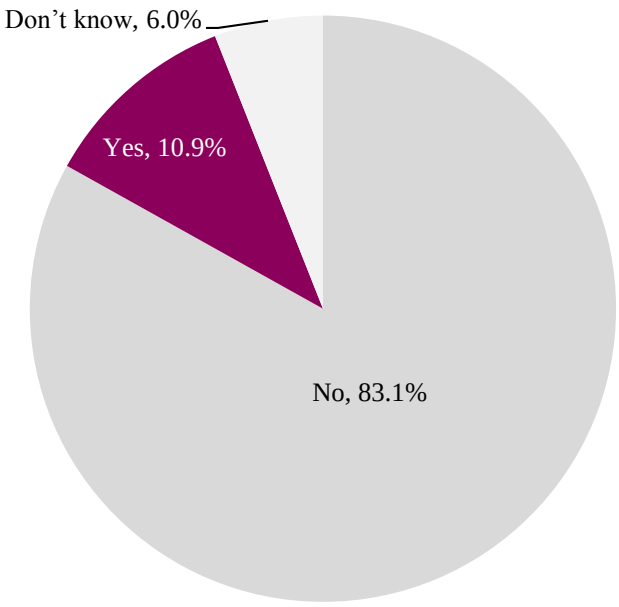


Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]



[22] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[23] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 34. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor (n=4,955)



Social and Emotional Well-Being

Exhibit 35. Percent of members who indicated they needed to see a mental health specialist (n=5,723)

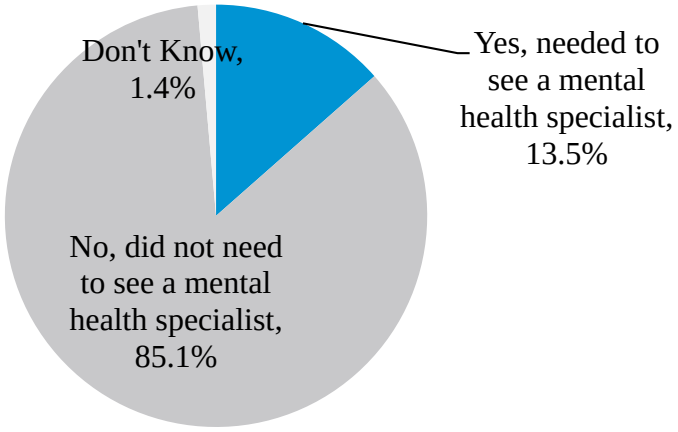


Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)

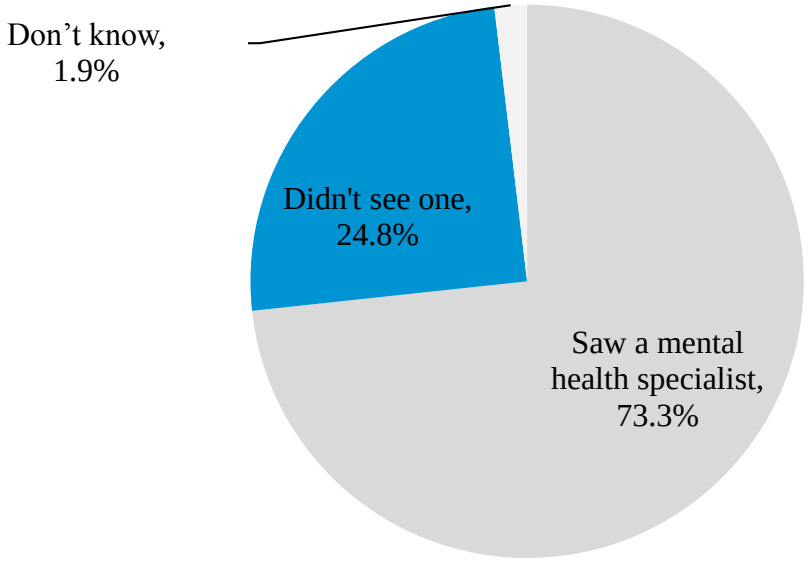


Exhibit 37. Reasons why members didn't see mental health specialist[24]

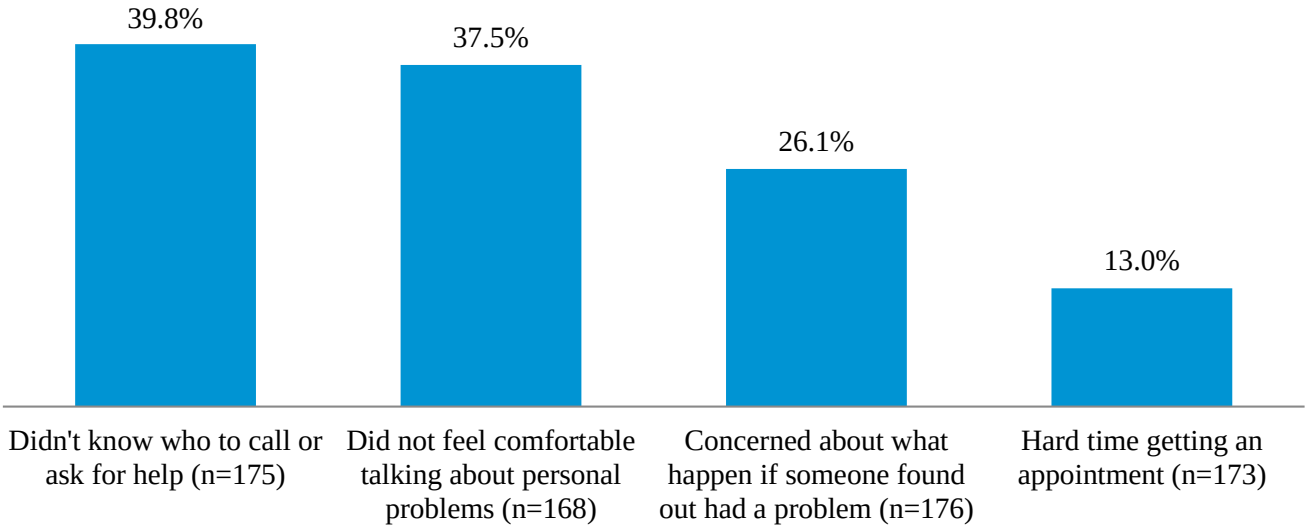
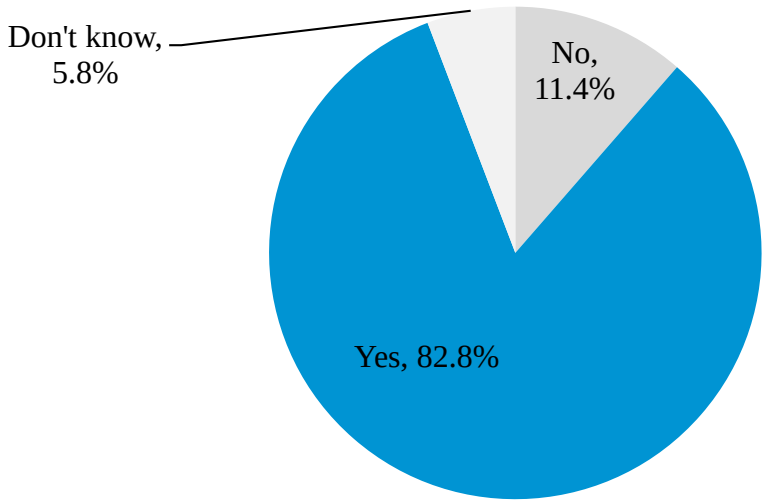


Exhibit 38. Percent of members who can share their worries with family members (n=5,670)



[24] Among those who indicated that they needed to see a mental health specialist but did not see one.

Social Determinants of Health

Exhibit 39. Percent of members who needed help with basic needs in the past 6 months:

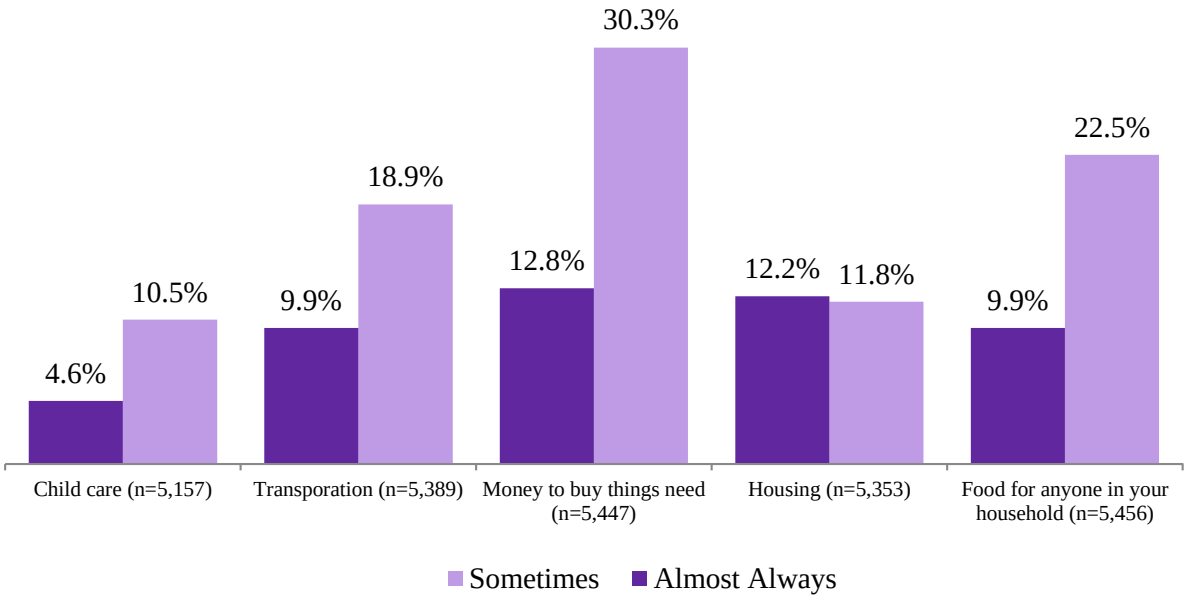


Exhibit 41. Percent of members who receive public benefits (n=5,117):

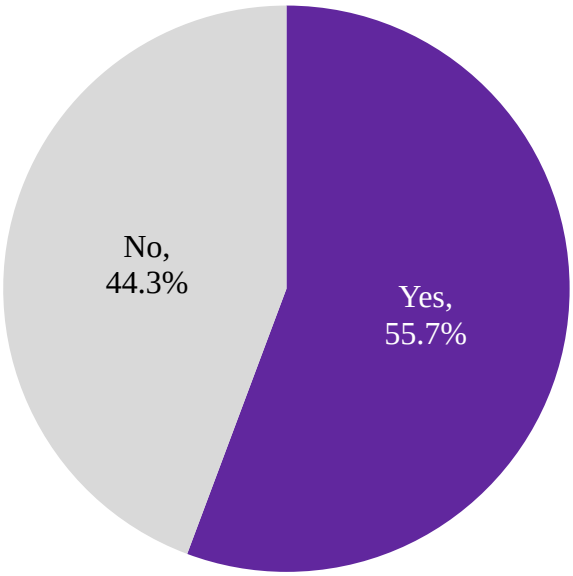
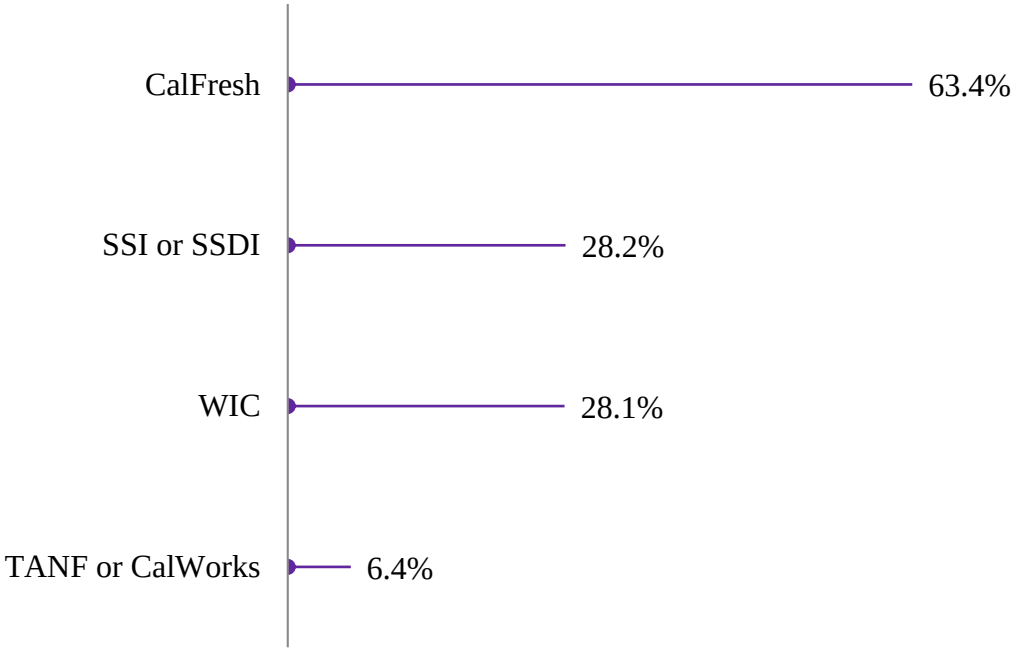


Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:

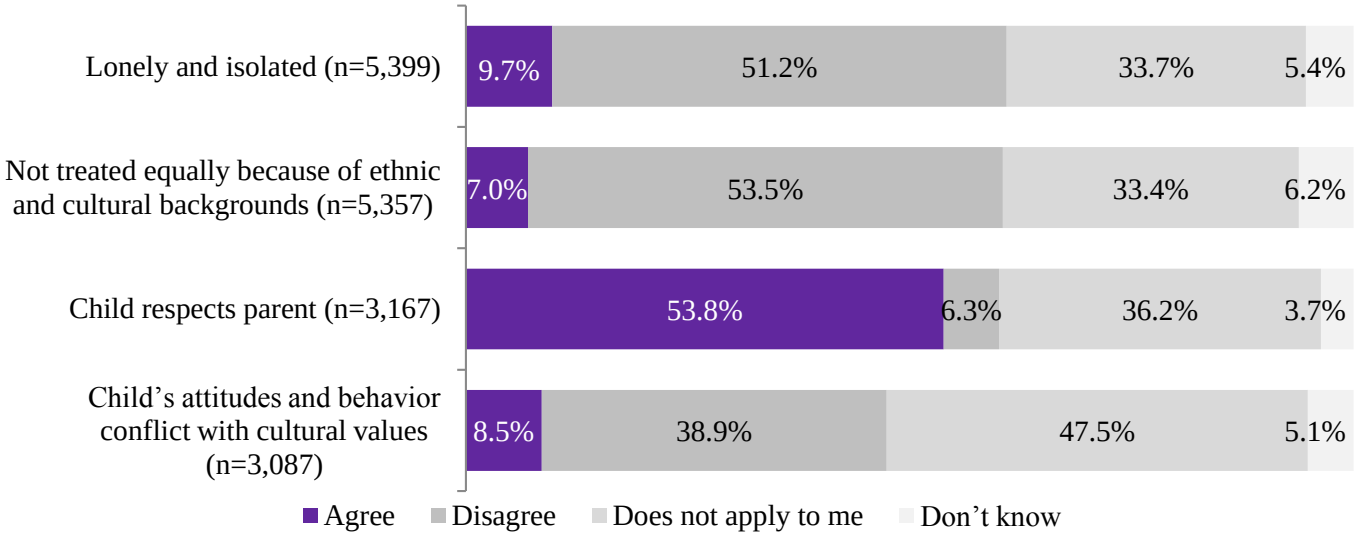


[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

Exhibit 43. Personal activities members participant in:

	Once a week	Once a month	Once in the last 6 months	Never	n
Care for a family member	36.2%	5.6%	5.1%	53.1%	5,209
Fun with others	61.9%	17.0%	6.6%	14.6%	5,396
Volunteer or Charity	16.4%	14.2%	17.3%	52.1%	5,288
Physical fitness	68.4%	10.2%	4.8%	16.7%	5,393
Attend religious centers	48.7%	11.1%	10.8%	29.4%	5,470
Get enough sleep	83.5%	5.8%	1.1%	9.6%	5,119
Enough time for self	77.4%	10.6%	3.1%	8.8%	5,209
Enough time for family	81.5%	8.5%	3.1%	6.9%	5,274
Gambling activities	0.9%	0.8%	4.8%	93.5%	5,378

Exhibit 44. Feelings towards community and home enviroment[26]:



[26] Only reported for those over 18 years old for "Child respects parent" and "Child's attitudes and behavior conflict with cultural values."

Exhibit 45. How well members speak English (n=5,549)

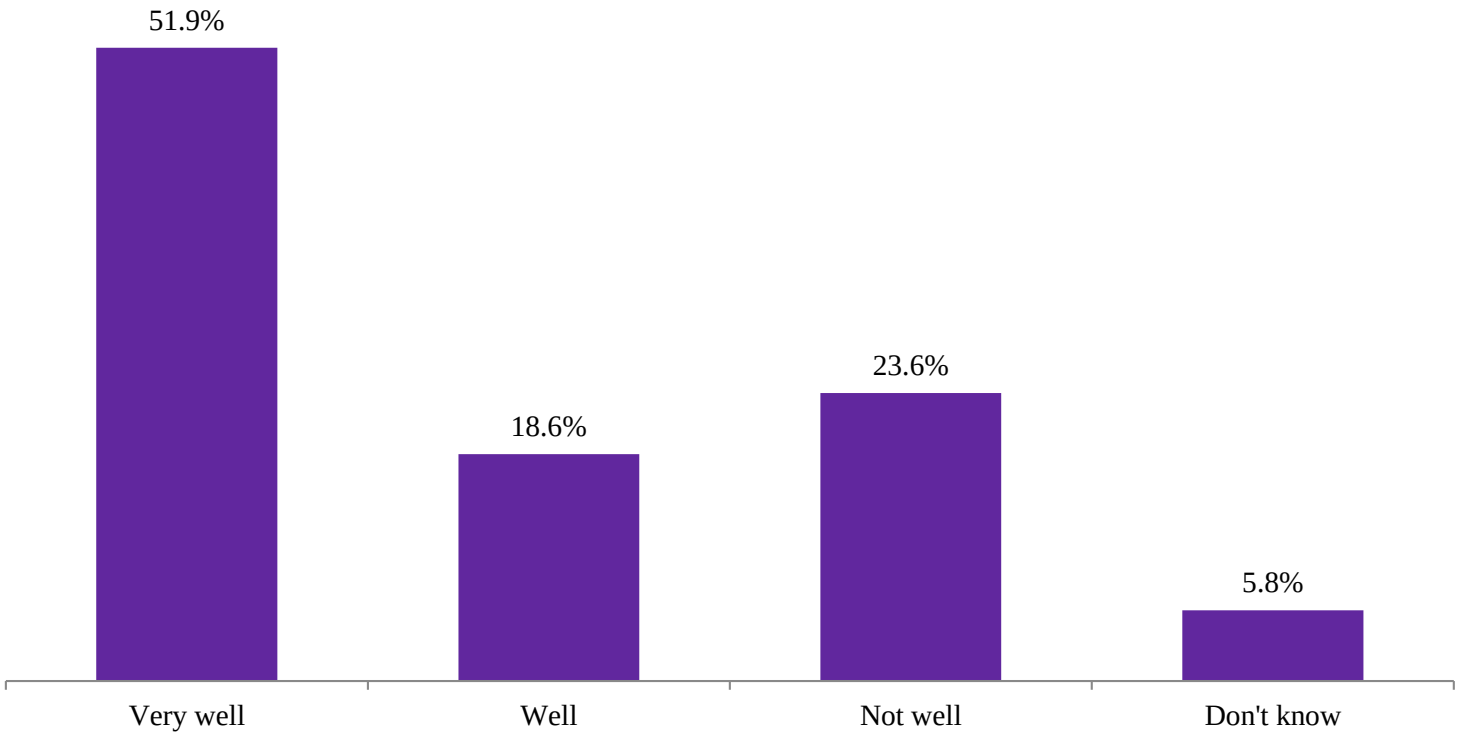


Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]

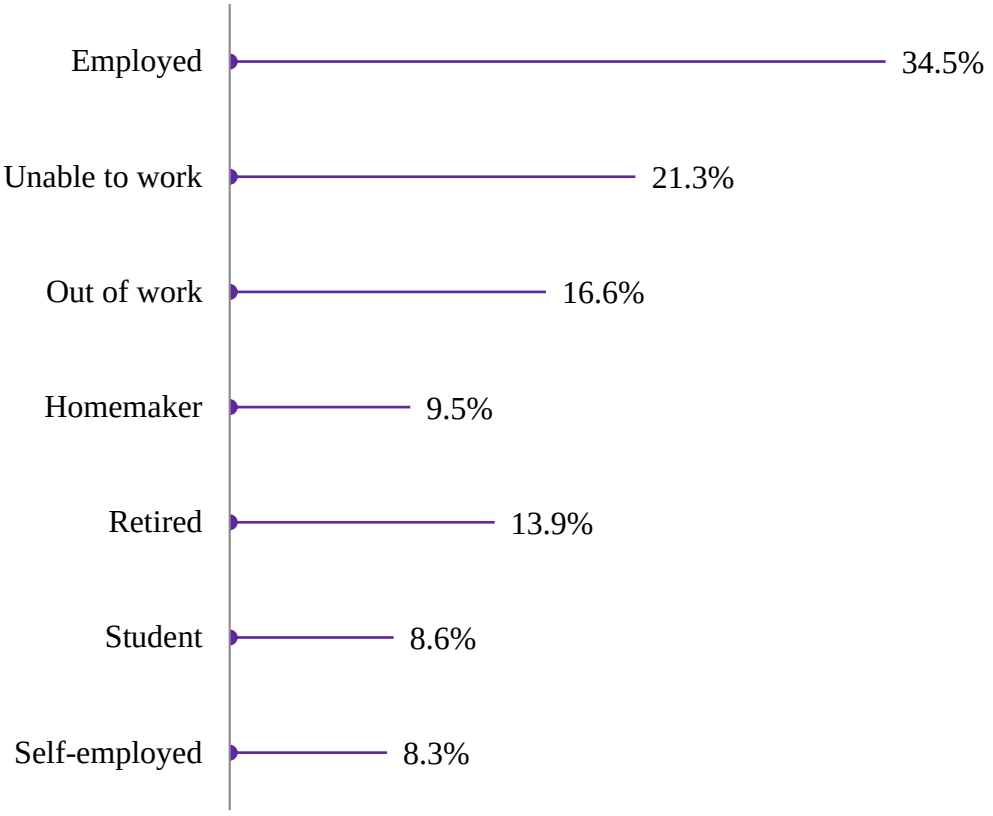
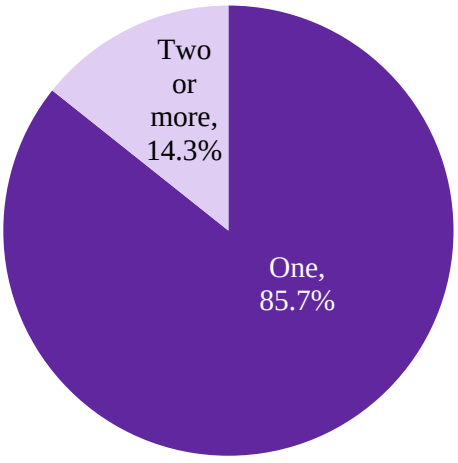
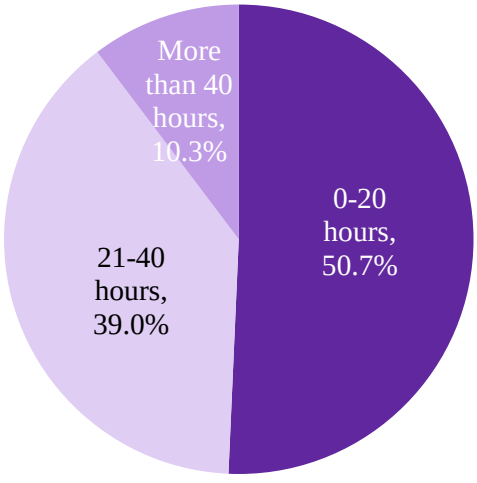


Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]

Number of jobs members have



Number of hours that members work each week



[27] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[28] Only reported the members who are over 18 years old.
[29] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

Exhibit 48. Members' living situation (n=5,590)

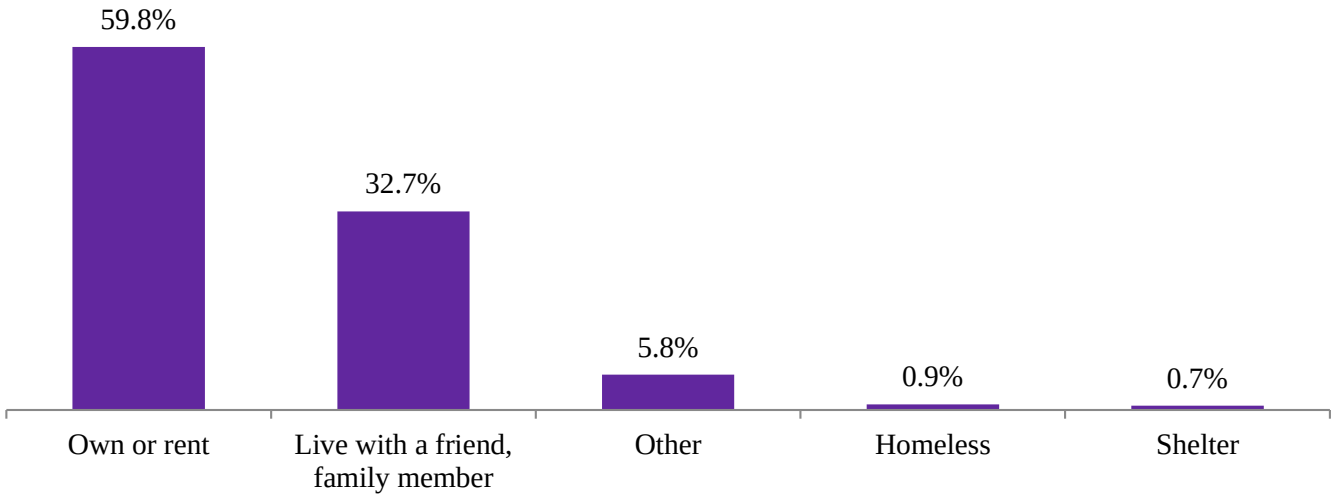
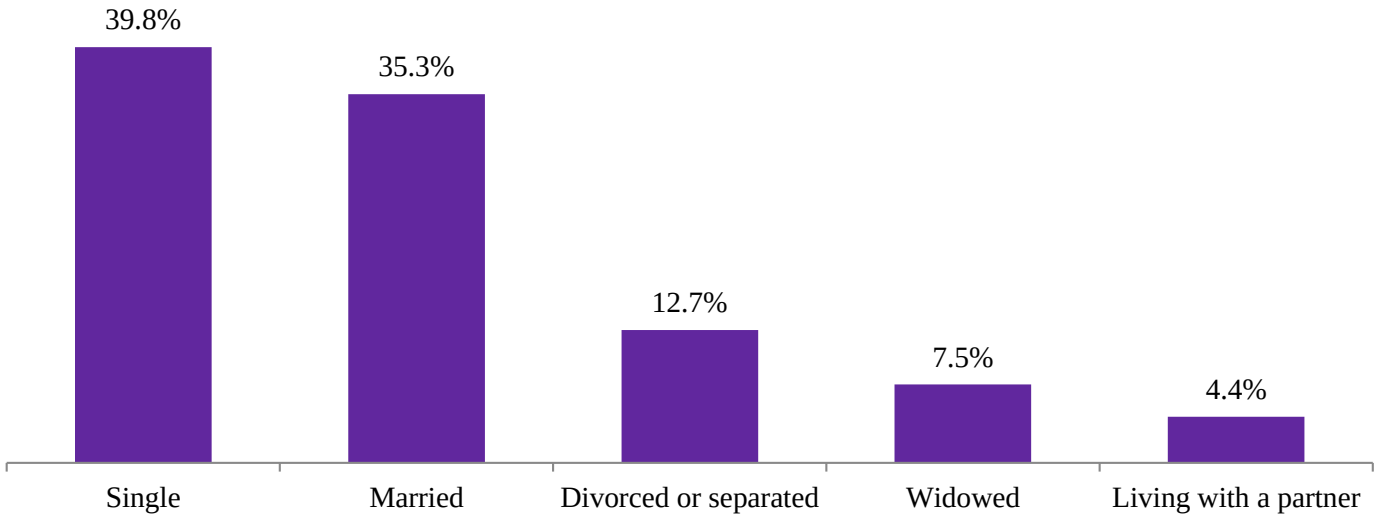


Exhibit 49. Marital status of members (n=3,271)[30]



[30] Only reported those who are over 18 years old.

Exhibit 50. Percent of members who were born in the United States (n=5,599)

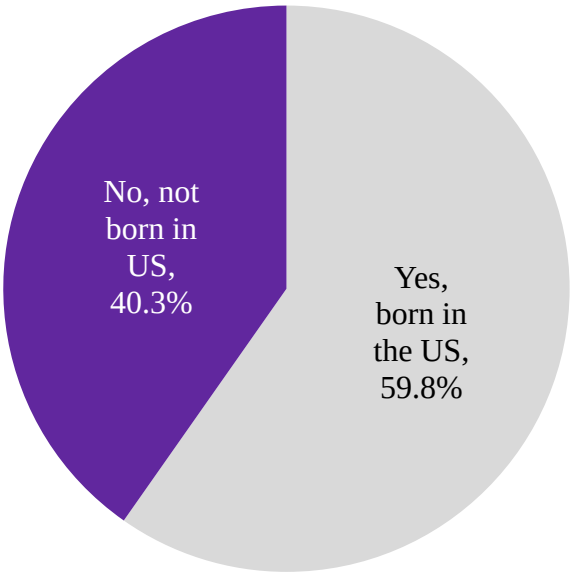
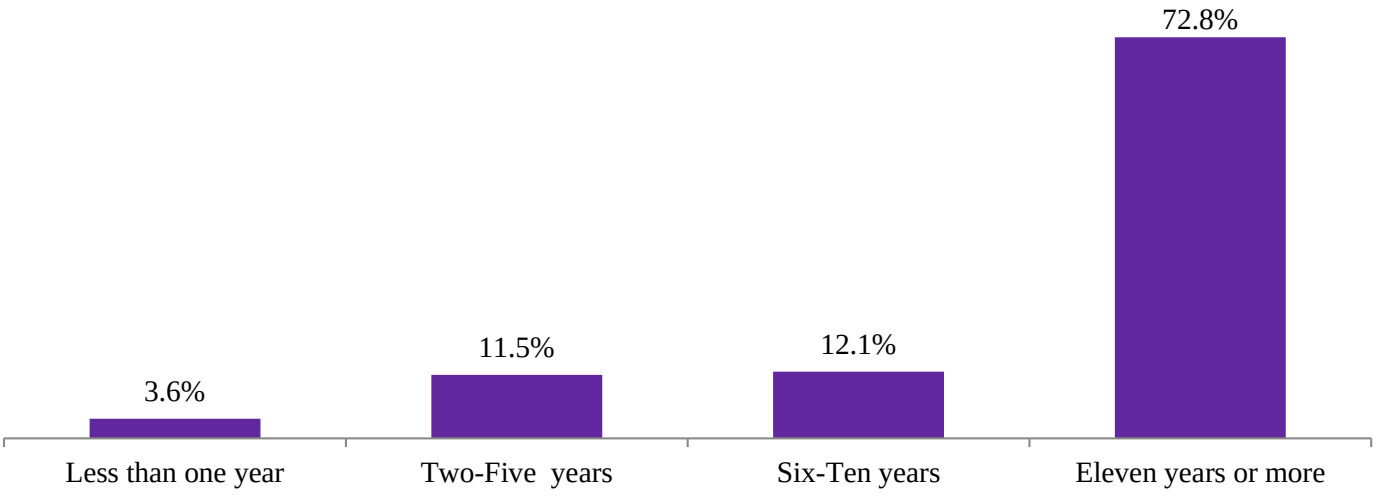


Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]



[31] Of those who were born outside of the U.S.

Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

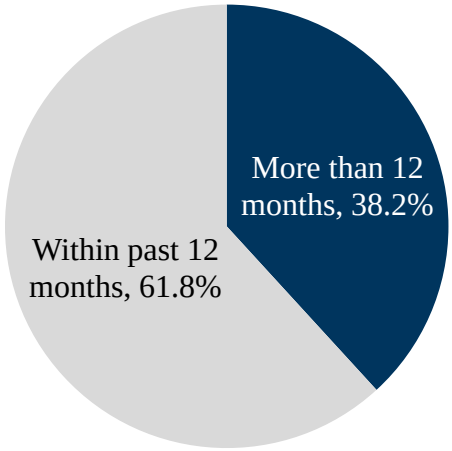
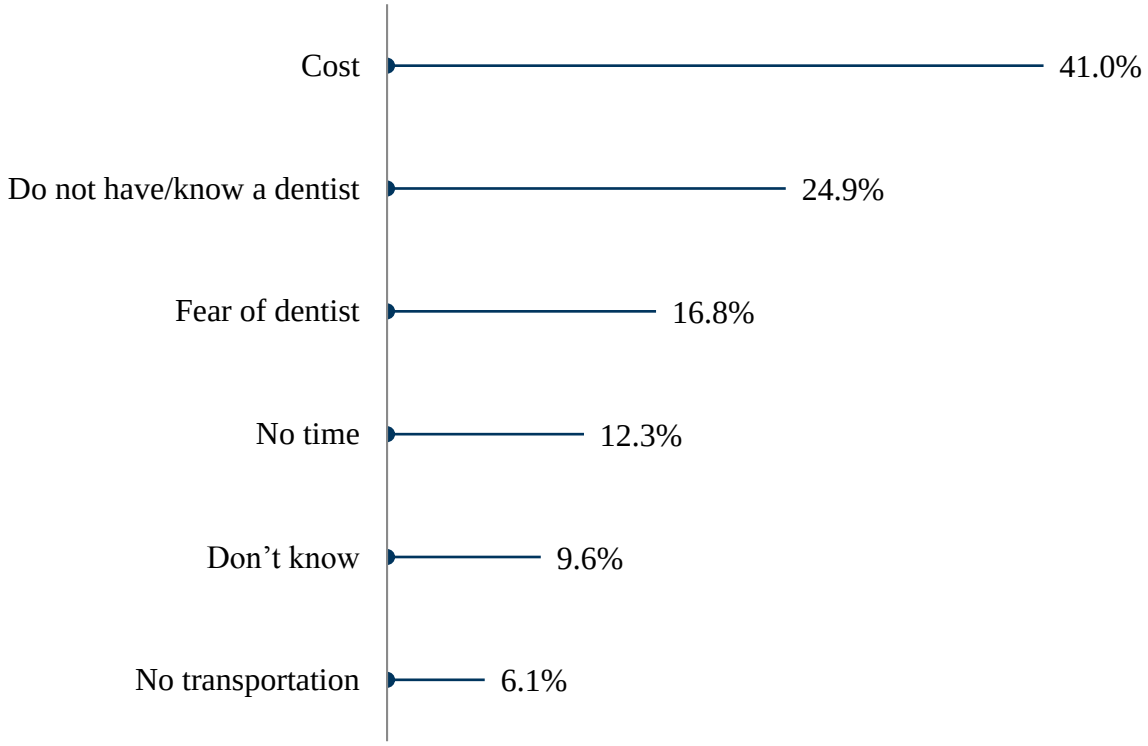
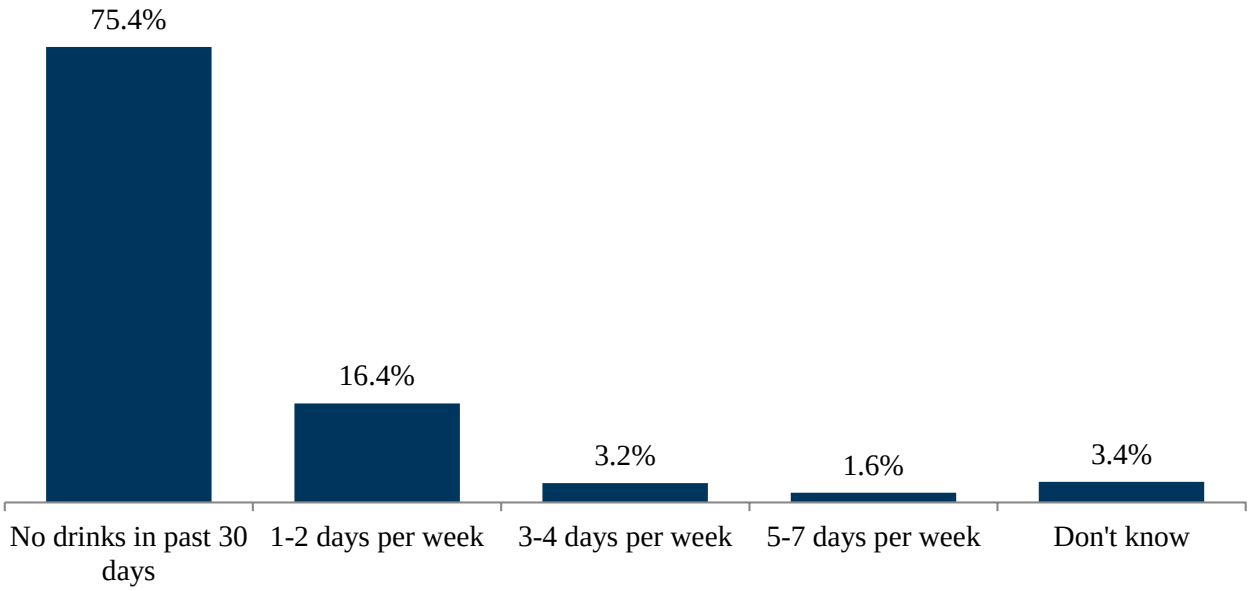


Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]



[32] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[33] Only reported those who have not seen a dentist within the past 12 months.

Exhibit 54. Days per week member had at least one drink of alcoholic beverage during the past 30 days (n=3,083)[34]



[34] Only reported those who are 18 years or older.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Cheryl Meronk, Director, Strategic Development, (714) 246-8400

Recommended Actions

1. Authorize the release of Requests for Proposal (RFPs) for community grants with staff returning at a future Board meeting with recommendations for award decisions; and
2. Authorize the reallocation of IGT 2 funds remaining from the Autism Screening project to Community Grants consistent with the state-approved IGT 2 approved funding categories.

Background

In December 2016, the CalOptima Board of Directors authorized an allocation of IGT 5 funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to address the unmet needs identified by the MHNA.

At the February 2018 Board of Directors meeting, staff presented the Executive Summary of the MHNA as well as categories of needs in the community identified by the MHNA. The Board-approved categories included:

- Adult Mental Health
- Older Adult Mental Health
- Children's Mental Health
- Nutrition Education and Physical Activity
- Children's Dental Services
- Medi-Cal Benefits Education and Outreach
- Primary Care Access and Social Determinants of Health
- Adult Dental Services

After the June 7, 2018 Board of Directors meeting, CalOptima released a notice for Requests for Information (RFI) from organizations to better define the scopes of work to address community needs in one or more of the above referenced categories. CalOptima received a total of 93 RFI responses from community-based organizations, hospitals, county agencies and other community interests. The 93 RFI responses are listed as follows:

MHNA Categories	# of RFIs
Adult Mental Health	15
Older Adult Mental Health	13
Children's Mental Health	13
Nutrition Education and Physical Activity	12
Children's Dental Services	5
Medi-Cal Benefits Education and Outreach	10
Primary Care Access and Social Determinants of Health	19
Adult Dental Services	6
TOTAL	93

Subject matter experts and grant administrative staff performed an examination of all the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

The Ad Hoc Committee, comprised of Supervisor Do and Director DiLuigi, met on November 9, 2018 to discuss the results of the 93 RFI responses for the MHNA categories and review the staff-recommended RFPs for consideration.

Following the review of the RFI responses, the staff evaluation process and recommendations, the Ad Hoc committee recommended moving forward with the following Community Grant categories:

Community Grant Requests for Proposal (RFPs)

Grant RFP	Total Grant Award
1. Access to Children's Dental Services	$1,000,000
2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	$1,400,000
3. Access to Adult Dental Services	$1,000,000
TOTAL	**$3,400,000**

Staff is also recommending the reallocation of an amount up to $400,000 remaining from the IGT 2 Autism Screening Project to support these community grants. This provider incentive project aimed at increasing the access to autism screenings for CalOptima children members has been discontinued. The program was able to screen a total of 110 children. Support of the grant RFPs fulfills the original Board-approved uses of the IGT 2 funds which were as follows:

1. Enhance CalOptima's core data analysis and exchange systems and management information technology infrastructure to facilitate improved coordination of care for Medi-Cal members;
2. Continue and/or expand on services and initiatives developed with 2010-11 IGT funds;
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health integration, preventive dental services and supplies, and incentives to encourage members to participate in initial health assessment and preventive health programs.

Funding for the above grant RFPs is derived as follows:

- **$3.0 million**: Remaining from IGT 5 (following anticipated Board action related to other IGT 5 funds)
- **$0.4 million:** Reallocation from IGT 2 Autism Screening Project
- **$3.4 million:** Total available for distribution through Community Grants

Following receipt and review of the RFP responses, evaluation committees consisting of staff and other subject matter experts will evaluate the responses based on a standardized scoring matrix, and will return to the Board with recommendations and proposed funding allocations.

Fiscal Impact

Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations. The recommended action to authorize the release of the Requests for Proposal (RFPs) for community grants has no additional fiscal impact to CalOptima.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence

Gary Crockett, Chief Counsel

Attachment

PowerPoint Presentation: Community Grant RFP Recommendations

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

11/28/2018 — **Date**

CalOptima
A Public Agency
Better. Together.

Community Grant RFP Recommendations

Board of Directors Meeting
December 6, 2018

Cheryl Meronk
Director, Strategic Development

IGT 5 Process Summary to Date

Board authorizes Member Health Needs Assessment (MHNA) to guide expenditure of IGT5 funds

MHNA identifies categories for community grants

Board authorizes Requests for Information (RFIs) to better define the scopes of work in each of the categories

93 RFI responses lead to the identification possible Requests for Proposal (RFPs)

Board Ad Hoc committee meets to consider recommending that the full Board authorize RFPs

IGT 5 Expenditure Process

- Subject matter experts and grant administrative staff evaluated/scored all 93 RFI responses by category
  - Evaluation committees met July 30–August 9
  - Provided recommendations on scopes of work to be developed into RFPs

- Ad Hoc Committee reviewed all 93 RFI responses
  - Recommended grant to Be Well OC for first Wellness Hub
  - 3 RFPs proposed

Grant Funding

- **$14.4M** CalOptima's share of IGT 5
- **-$11.4M** Recommended grant to Be Well OC for first Wellness Hub
- **$ 3.0M** Remaining for recommended distribution for Community Grants
- **$ 400K** Re-allocation from IGT 2 Autism Screening Project
- **$ 3.4M** **Total Available for Community Grants**

Three Recommended Grant RFPs

RFP #	RFP Description	Funding Amount
1	Access to Children's Dental Services	$1 million
2	Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	$1.4 million
3	Adult Dental Services	$1 million
	Total	**$3.4 million**

* Multiple awardees may be selected per RFP

RFP 1

Access to Children's Dental Services and Outreach

- **Funding Amount:** $1 million
- **Description:**
  - Provide mobile dental outreach at schools with preventative, restorative treatment/services as well as outreach and education for examinations, screenings, resources, etc.
  - Assist children/families with establishing a dental home close to their home for emergency and regular dental care
  - Provide or partner with other community dental providers to ensure patients receive restorative and other specialty dental services in addition to exams and screenings as needed

RFP 2

Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)

- **Funding Amount:** $1.4 million
- **Description:**
  - Establish and/or operate school-based wellness centers where family, staff and community partners collaborate to align resources
  - Partner with health clinics that allow for school referrals and follow-up care
  - Provide health assessment/screenings on school campuses and community-based education for families

RFP 3

Adult Dental Services and Outreach

- **Funding Amount:** $1 million
- **Description:**
  - Expand availability of dental services/treatment at health centers and/or mobile units with medical care integration for comprehensive health care
  - Ensure provider/staff capacity to perform assessment and restorative dental services
  - Expand dental services to nontraditional evening and weekend hours
  - Establish collaboration with community clinics/resources for specialized dental care

Next Steps*

Mid-December 2018: CalOptima releases Community Grant RFPs, if approved

January 2019: RFP responses due

March 2019: Ad Hoc reviews recommended grant awards

April 2019: Board considers approval of grant awards

April 2019: grant agreements executed

* Dates are subject to change based on Board approval

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
15. Consider Allocation of Intergovernmental Transfer 5 Funds

Contact
Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions
1. Approve the recommended allocations of IGT 5 funds in the total amount of $3.4 million for community grants; and,
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute grant contracts with the recommended community grantees.

Background
Intergovernmental Transfers (IGTs) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT 1-7 funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus IGT 1-7 funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries. Beginning with IGT 8, the IGT funds are viewed by the state as part of the capitation payments CalOptima receives; these payments are to be tied to covered Medi-Cal services provided to Medi-Cal beneficiaries.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net.

On December 1, 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) the results of which would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per the approved priority areas. The MHNA data collection activities were completed in November 2017.

On February 1, 2018, a summary of MHNA results was shared with the CalOptima Board of Directors. Based on the results of the MHNA, the Board additionally approved the release of eight RFPs for $14.4 million community grants in the following categories:

- Adult Mental Health
- Older Adult Mental Health

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- Children's Mental Health
- Nutrition Education and Physical Activity
- Children's Dental Services
- Medi-Cal Benefits Education and Outreach
- Primary Care Access and Social Determinants of Health
- Adult Dental Services

In preparation for the release of the RFPs, staff recognized a need to narrow and better define a more precise and definitive Scope of Work (SOW) for each category. On June 7, 2018, the CalOptima Board approved release of Requests for Information related to these eight categories; ninety-three responses in July 2018.

On December 6, 2018, the CalOptima Board of Directors approved $11.4 million of IGT 5 funds to the Be Well Wellness Hub in December 2018. At that time, the Board of Directors also approved the release of the three following RFPs in the total amount of $3.4 million ($3 million remaining in IGT 5 and $400,000 reallocated from IGT 2) for community grants.

Request for Proposal	Priority Area	Allocation Amount
1. Access to Children's Dental Services	Strengthening the Safety Net	$1.0 million
2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	Strengthening the Safety Net	$1.4 million
3. Adult Dental Services	Strengthening the Safety Net	$1.0 million

The three RFPs garnered 20 responses. External subject matter experts and staff performed an examination of all the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

The IGT 5 Ad Hoc committee comprised of Dr. Nikan Khatibi and Dr. Alexander Nguyen met on July 23, 2019 to discuss the results of the 20 RFP responses for Children's Dental Services, Primary Care Services and Programs Addressing Social Determinants of Health, and Adult Dental Services. Following

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the review of the evaluation committee results, the Ad Hoc committee is recommending the following allocation of $3.4 million for IGT 5 board-approved priority areas through three (3) RFPs.

Community Grants

Category	Organization	Funding Amount
RFP 1. Access to Children's Dental Services	Healthy Smiles for Kids of Orange County	$1,000,000
RFP 2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	Santa Ana Unified School District	$1,400,000
RFP 3 Adult Dental Services	KCS Health Center (Korean Community Services)	$1,000,000

Fiscal Impact

The recommended action to approve the allocation of $3.4 million from IGT 5 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: IGT 5 Expenditure Plan Allocation
2. CalOptima Board Action dated February 1, 2018, Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants
3. CalOptima Board Action dated June 7, 2018, Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)
4. CalOptima Board Action dated December 6, 2018, Consider Authorizing a Contract for Be Well Wellness Hub Services Provided to CalOptima Medi-Cal Members using Intergovernmental Transfer (IGT) 5 Funds
5. CalOptima Board Action dated December 6, 2018, Consider Authorizing Release of Requests for Proposal (RFPs) for Community Grants to Address Categories from the Intergovernmental

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Transfer (IGT) 5 Funded CalOptima Member Health Needs Assessment and Authorizing Reallocation of IGT 2 Funds.

6. List of responders by RFP category.

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

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IGT 5 Community Grant Award Consideration

Board of Directors Meeting

August 1 2019

Candice Gomez

Executive Director, Program Implementation

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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 5 priority areas for community-based funding opportunities
  - Childhood Obesity
  - Mental Health (Adult and Children's)
  - Improving Children's Health
  - Strengthening the Safety Net

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IGT 5 Background Summary

Board authorized Member Health Needs Assessment (MHNA) to guide expenditure of IGT5 funds

MHNA identified categories for community grants

Board authorized Requests for Information (RFIs) to better define the scopes of work in each of the categories

93 RFI responses lead to the identification possible Requests for Proposal (RFPs)

Board authorized the release of 3 RFPs

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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

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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

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RFP Summary

RFP	Total Received	Total Recommended
1. Access to Children's Dental Service ($1.0 million)	5	1
2. Primary Care Services & Social Determinants of Health ($1.4 million)	6	1
3. Access to Adult Dental Service ($1.0 million)	9	1
Total	**20**	**3**

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1. Access to Children's Dental Service ($1 million)

Organization	Original Request	Recommended Funding Amount
Healthy Smiles for Kids of Orange County	$1,000,000	$1,000,000
Total	**$1,000,000**	**$1,000,000**

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2. Primary Care Services & Social Determinants of Health ($1.4 million)

Organization	Original Request	Recommended Funding Amount
Santa Ana Unified School District	$1,400,000	$1,400,000
Total Awarded	**$1,400,000**	**$1,400,000**

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3. Access to Adult Dental Service ($1.0 million)

Organization	Original Request	Recommended Funding Amount
KCS Health Center (Korean Community Services)	$987,600	$1,000,000
Total	**$987,600**	**$1,000,000**

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Recommended Board Actions

- Approve the recommended allocations of IGT 5 funds in the amount of $3.4 million for community grants; and,
- Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contracts with the recommended community grantees.

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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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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

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#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

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6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

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Member Health Needs Assessment

Board of Directors Meeting
February 1, 2018

Cheryl Meronk
Director, Strategic Development

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Member Health Needs Assessment

A better study offering deeper insight, leading to a healthier future.

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A Better Study

- ➔ More Comprehensive
- ➔ More Engaging
- ➔ More Personal

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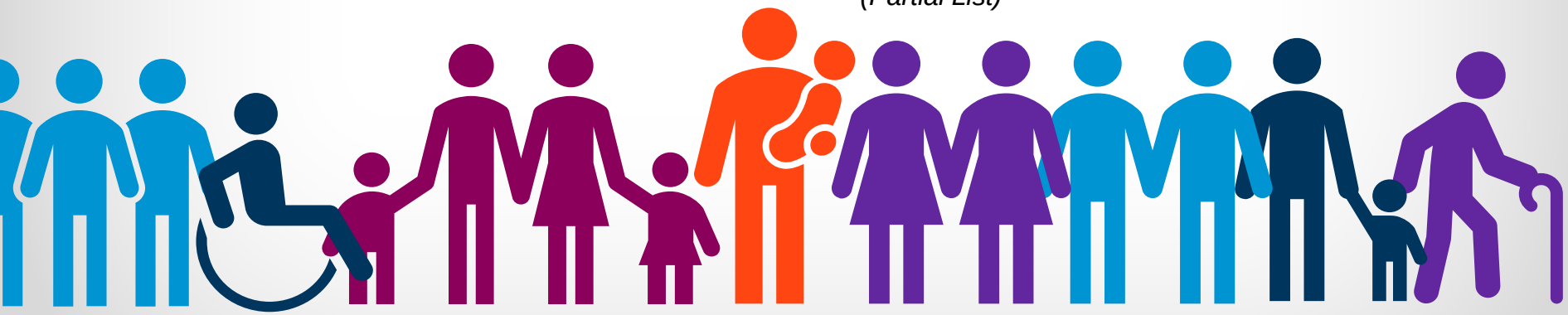
More Comprehensive

- Reached new groups of members whose voices have rarely been heard before
  - Young adults with autism
  - People with disabilities
  - Homeless families with children
  - High school students
  - Working parents
  - New and expectant mothers
  - LGBTQ teens
  - Homeless people in recuperative care
  - Farsi-speaking members of a faith-based group
  - PACE participants
  - Chinese-speaking parents of children with disabilities

(Partial List)



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More Comprehensive (Cont.)

- Gathered responses from all geographic areas of Orange County



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More Comprehensive (Cont.)

- Probed a broader view of members' lives beyond immediate health care needs
  - Hunger
  - Child care
  - Economic stress
  - Housing status
  - Employment status
  - Physical activity
  - Community engagement
  - Family relationships
  - Mental health
  - Personal safety
  - Domestic violence
  - Alcohol and drug consumption

(Partial List)



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More Comprehensive (Cont.)

- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In the past 12 months, did you have the need to see a mental health specialist?
  - How open are you with your doctor about your sexual orientation?
  - How sensitive are your health care providers in understanding your disability?

(Partial List)

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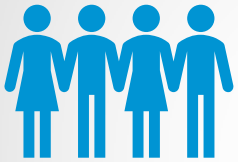
More Engaging: Members



Focus Groups

- 31 face-to-face meetings in the community
- 353 members



Telephone Conversations

- 534 live interviews in members' languages



Mailed Surveys

- Nearly 6,000 surveys returned



Electronic Responses

- More than 250 replied conveniently online

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More Engaging: Member Advocates

- Abrazar Inc.
- Access CA Services
- Alzheimer's OC
- Boys & Girls Club
- The Cambodian Family
- CHOC
- Dayle McIntosh
- La Habra Family Resource Center
- Latino Health Access
- Korean Community Services
- Mercy House
- MOMS Orange County
- OMID
- SeniorServ
- South County Outreach
- State Council on Developmental Disabilities
- Vietnamese Community of OC Inc.

(*Partial List)*

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More Personal

- Met in familiar, comfortable locations at convenient times for our members
  - Apartment complexes
  - Churches
  - Community centers
  - Schools
  - Homeless shelters
  - Recuperative care facilities
  - PACE center
  - Community clinics
  - Restaurant meeting rooms



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More Personal (Cont.)

- We spoke their language
  - English
  - Spanish
  - Vietnamese
  - Korean
  - Farsi
  - Chinese
  - Arabic
  - Cambodian
  - Marshallese
  - American Sign Language

The Voice of the Member

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Offering Deeper Insight

- → Barriers to Care
- → Lack of Awareness About Benefits and Resources
- → Negative Social and Environmental Impacts

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Notable Barriers to Care

- Study revealed that members encounter structural and personal barriers to care
  - Structural
    - It can be challenging to get an appointment to see a doctor
    - It takes too long to get an appointment
    - Doctors do not always speak members' languages
    - Interpreter services are not always readily available
    - Doctors lack understanding of members' cultures
  - Personal
    - Members don't think it is necessary to see the doctor
    - Members have personal beliefs that limit treatment
    - Members are concerned about their immigration status
    - Members are concerned someone would find out they sought mental health care

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Barriers to Care (Cont.)

Examples

52%

Don’t think it is necessary to see the doctor for a checkup

28%

Takes too long to get an appointment

26%

Concerned someone would find out about mental health needs

41%

Didn’t think it is necessary to see a specialist, even when referred

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Notable Lack of Awareness

- Survey revealed a lack of understanding about available benefits and services
  - 25 percent of members who needed to see a mental health specialist did not pursue treatment
  - 38 percent of members had not seen a dentist in more than a year

- Focus group participants commented frequently about having difficulty regarding certain resources
  - Interpreter services
  - Social services needs
  - Transportation

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Lack of Awareness (Cont.)

Examples

40%

Didn't know who to ask for help with mental health needs

41%

Didn't see a dentist because of cost (i.e., didn't know dental care was covered)

25%

Don't have or know of a dentist

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Negative Social and Environmental Impacts

- Survey revealed significant social and environmental difficulties
  - Lack of well paying jobs and employment opportunities
  - Lack of affordable housing
  - Social isolation due to cultural differences, language barriers or fear of violence
  - Economic insecurity and financial stress
  - Lack of walkable neighborhoods and the high cost of gym programs

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Negative Impacts (Cont.)

Examples

32%
Needed help getting food in the past six months

56%
Accessing other public assistance

43%
Needed help to buy basic necessities

29%
Needed help getting transportation

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Negative Impacts (Cont.)

Stakeholder Perspective

> There's a significant issue with improper nutrition. They may not have enough money or the ability to go to the grocery store to buy the right foods. They get what they can, and that's what they eat.
>
> *—Interviewee*

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Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

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Funding

$14.4 Million

Total Available IGT 5 Funds

- **Member Health Needs Assessment results drive funding allocations**

- **Eight Requests for Proposal (RFPs) to expand access to mental health, dental and other care, and outreach/education services**

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RFP 1

Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $5 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category
Adult Mental Health

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RFP 2

Expand Mental Health and Socialization Services for Older Adults

Funding Amount: $500,000

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category
Adult Mental Health

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RFP 3

Expand Access to Mental Health/ Developmental Services for Children 0–5 Years

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Shortage of pediatric mental health professionals
- ✓ Shortage of children's inpatient mental health beds
- ✓ Increase in adolescent depression

Funding Category
Children's Mental Health

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RFP 4

Nutrition Education and Fitness Programs for Children and Their Families

Funding Amount: $1 million

Findings Addressed

- ✓ Healthier food choices can be more expensive, less convenient and less accessible
- ✓ Cultural foods may not be the healthiest options
- ✓ Lack of time and safe places may limit physical activity

Funding Category
Childhood Obesity

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RFP 5

Medi-Cal Benefits Education and Outreach

Funding Amount: $500,000

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits

Funding Category

Supporting the Safety Net

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RFP 6

Expanded Access to Primary Care and Programs Addressing Social Determinants of Health

Funding Amount: $4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Lack of ability to cover basic necessities

Funding Category
Supporting the Safety Net

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RFP 7

Expand Adult Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1.4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Limited dental providers for adults

Funding Category
Supporting the Safety Net

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RFP 8

Expand Access to Children's Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not utilizing covered services
- ✓ Challenging to get an appointment to see a provider

Funding Category
Children's Health

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Moving Forward

- Eight Grant Applications/RFPs
  - Expand access to mental health, dental and other care services
  - Expand access to childhood obesity services regarding nutrition and fitness
  - Support outreach and education regarding social services and covered benefits
- RFPs to be released in March 2018
- Recommended grantees to be presented at June Board meeting

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EXECUTIVE SUMMARY
MEMBER HEALTH NEEDS ASSESSMENT

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In summer and fall 2017, more than 6,000 CalOptima members, service providers and community representatives participated in one of the most extensive and inclusive member health needs assessments (MHNA) undertaken by CalOptima in its 20-plus year history. The MHNA provides data critical to ensuring that CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima participates in numerous efforts to assess the health of Orange County's residents and create community-driven plans for improving the health of the Medi-Cal population. Some examples are detailed below.

- The 2013 Orange County Health Profile, produced by the Orange County Health Care Agency, highlighted key health indicators as well as other social, economic and environmental indicators that impact health conditions in groups of people based on economics, race, ethnicity, gender, age and geography.
- The 2016 Orange County Community Indicators Report tracked and analyzed Orange County's health and prosperity on a myriad of issues.
- The 2017 Conditions of Children in Orange County Report offered a comprehensive and detailed summary of how children in Orange County fair in the areas of health, economic well-being, educational achievement, and safe homes and communities.
- CalOptima's Group Needs Assessment, conducted every five years with annual updates in between, identifies members' needs, available health education, cultural and linguistic programs, and gaps in services.

When combined, these assessments provide a broad picture of important health information in Orange County. However, they do not focus specifically on Medi-Cal beneficiaries or on ethnic and linguistic minorities within this population, whose health needs are at the core of CalOptima's mission. For this reason, CalOptima undertook this comprehensive MHNA, summarized on the following pages.

By the Numbers

5,815
Surveys

31
Focus Groups

24
Stakeholder Interviews

21
Provider Surveys

10
Languages

Birth–101
Years of Age

Back to Agenda

CalOptima's comprehensive MHNA is an innovative collaboration that builds upon existing data-gathering efforts and takes them a step further. The study was designed to be a more comprehensive assessment, using engaging methods that resulted in a much more personal experience for our members and the community. The MHNA captures the unique and specific needs of Medi-Cal beneficiaries from an array of perspectives, including providers, community leaders and, most importantly, the members themselves. As a result, this in-depth study offers actionable recommendations for consideration by the CalOptima Board of Directors and executive leadership.

The MHNA was designed to help CalOptima identify:

1. Unique needs and challenges of specific ethnic communities, including economic, social and environmental stressors, to improve health outcomes

2. Challenges to health care access and how to collaborate with community-based organizations and providers to address these barriers

3. Member awareness of CalOptima services and resources, and effective strategies to increase awareness as well as disseminate information within target populations

4. Ways to leverage outreach efforts by partnering with community-based organizations on strategic programs

Our Partners

To guide the direction of the study, CalOptima established an MHNA Advisory Committee made up of community-based representatives. The committee then engaged CalOptima staff and Harder+Company Community Research (Harder+Company), in partnership with the Social Science Research Center (SSRC) at California State University, Fullerton. A summary of their qualifications to participate in this extensive effort is below.

Harder+Company was founded in 1986 and works with philanthropic, nonprofit and public-sector clients nationwide to reveal new insights about the nature and impact of clients' work. Harder+Company has a deep commitment to lifting the voices of marginalized and underserved communities — and working across sectors to promote lasting change. In addition, Harder+Company offers extensive experience working with health organizations to plan, evaluate and improve services for vulnerable populations, along with deep experience assisting hospitals, health departments and other health agencies on a variety of efforts, including conducting needs assessments, engaging and gathering meaningful input from community members, and using data for program development and implementation.

SSRC was established in 1987 to provide research services to community organizations and research support to university faculty. The center's primary goal is to assist nonprofit and tax-supported agencies and organizations to answer research questions that will lead to improved service delivery and public policy. The SSRC conducts surveys, evaluation research and other applied research activities to meet its clients' information needs. The center conducts multilingual telephone surveys from its 24-station computer-assisted telephone interviewing lab, as well as web-based, mailed and face-to-face surveys. In the past 10 years, SSRC has successfully completed 200 telephone survey projects using a variety of sample designs in diverse areas of focus, such as health care, public safety, education, workforce development and pregnancy prevention.

harder + co | community research

CALIFORNIA STATE UNIVERSITY FULLERTON

Due to strong partnerships with the community, the 2017 MHNA engaged members who may be hard to reach. We are proud that our efforts included:

- Young adults on the autism spectrum
- People with disabilities
- Homeless families and children
- High school students
- Working parents
- New and expectant mothers
- LGBTQ teens
- Farsi-speaking members of faith-based groups
- PACE participants
- Chinese-speaking parents of children with disabilities

More Comprehensive

To represent CalOptima's nearly 800,000 members, an in-depth analysis was performed to uncover their unique needs and challenges. An oversampling was thoughtfully incorporated in the calculation of responses needed to achieve a true statistical representation of the Orange County Medi-Cal population. For the mailed survey, more than 42,000 members were selected within a specific sampling frame that included language, age range and region.

With the oversampling, the aim was to collect 4,000 responses with targets for each subgroup. The final data collection results were far beyond the goal in every subgroup. More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

The assessment gathered responses from all geographic areas of Orange County, across all age groups and 10 languages. Additionally, the assessment reached new groups of members whose voices have rarely been sought out or heard before, such as young adults with autism, people with disabilities and homeless families with children.

Ultimately, the assessment concentrated on the underlying social determinants of health that have been recognized as factors that impact the health of individuals. The MHNA probed a broader view of members' lives beyond immediate health care needs to explore issues related to:

- ☑ Hunger
- ☑ Child care
- ☑ Economic stress
- ☑ Housing status
- ☑ Employment status
- ☑ Physical activity
- ☑ Community engagement
- ☑ Family relationships
- ☑ Mental health
- ☑ Personal safety
- ☑ Domestic violence
- ☑ Alcohol and drug use

More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

More Engaging

The MHNA used a mixed-methods approach to engage members who generally have been underrepresented in previous assessments as well as community stakeholders who work directly with the Medi-Cal population. The data collection effort was extensive, incorporating both qualitative and quantitative methods and going beyond previous processes in Orange County. The mixed-methods approach consisted of the following:

Member Survey

5,815 members completed an in-depth 50-question survey that was available in each of CalOptima's seven threshold languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic. As described further below, three additional languages that are less common in Orange County were also incorporated to ensure the assessment was comprehensive. Most surveys were completed and returned via mail (86 percent), with 9 percent completed via telephone and 5 percent online. Telephone calls were made to reach members who were homeless or more transient and may not have a permanent address. An online survey was offered for members' convenience.

Provider Survey

An online survey of 20 questions was sent to a broad sample of providers in CalOptima's network to seek insight on the challenges that members face. Providers identified what they perceive as the top problems for Medi-Cal members as well as barriers for these members in accessing health care. There were 21 network or physician medical groups that completed the provider survey.

Focus Groups

31 focus groups were conducted with members in partnership with community-based organizations across Orange County. Focus groups allowed for face-to-face conversations with members in comfortable and familiar environments, which helped to foster organic, open-ended discussions where members felt safe to share their thoughts. The discussions were conducted in CalOptima's seven threshold languages, as well as Cambodian, Marshallese and American Sign Language. Focus group conversations covered numerous key topics, including quality of life, community assets, barriers to accessing care, violence, behavioral health, chronic disease, and health practices, such as healthy eating and active living.

Key Stakeholder Interviews

24 leaders from community-based organizations participated in the interviews. Those chosen for the study have direct interactions with Medi-Cal members or serve as advocates for Orange County's vulnerable population. Interviews focused on key health issues facing Medi-Cal members, the provision of culturally competent services, and the social determinants of health, such as economic and environmental factors.

In the spirit of collaboration, individuals and groups in the community came together in a remarkable way to demonstrate their dedication to CalOptima members. Countless hours were spent planning, engaging and meeting with members. For example, in addition to serving as stakeholder interviewees, many of CalOptima's community partners reached out to members to encourage them to respond to the surveys, and they also hosted and recruited members to focus group meetings. Community organizations were invaluable in helping members feel comfortable with the process and in providing another view into members' lives. The engagement of community partners and member advocates was instrumental in the success of the MHNA.

More Personal

The MHNA aimed to give CalOptima members a more personal experience by hosting focus group conversations in familiar locations at convenient times, often evenings and weekends. These settings were intentionally selected based on members' comfort levels. Focus groups were also held at specific times to ensure that members could have their voices heard without having to miss work, school or other obligations. Focus groups were conducted in 10 languages enabling members to respond in their preferred spoken language.

Focus groups were held at:

- Apartment complexes
- Churches
- Community centers
- Schools
- Homeless shelters
- Recuperative care facilities
- PACE center
- Community clinics
- Restaurant meeting rooms

Methods

With a strong focus on engaging a representative sample of CalOptima members, Harder+Company and SSRC developed the sample frame to capture a breadth of perspectives as well as focus on the specific needs of key populations. Although the purpose of the MHNA was to assess the needs of Medi-Cal members in Orange County overall, Harder+Company and SSRC sought to gain a better understanding of the needs of CalOptima's non-English speakers by purposefully oversampling all seven subgroups. The oversampling of members designated as speaking one of the seven threshold languages ensured that CalOptima and community stakeholders can be 95 percent confident that the true population parameters for any particular subgroup will fall between +/- 5 percent of the observed sample estimate.

At more than 5,800 members, the survey response far exceeded the target number of respondents in the sampling frame. The robust response was due to a comprehensive data collection plan that included communication with members and partners in advance of sending the survey, reminder phone calls and multilingual computer-assisted telephone interviewing for members preferring to respond by phone.

Survey data was entered, monitored and quality checked by SSRC before being exported for analysis by Harder+Company. All variables were screened to determine the amount of missing data, and basic frequencies were initially computed for each question by language, region and age. To adjust for the oversampling built into the sampling frame, comprehensive statistical analysis was then completed applying weights calculated by SSRC. Additional analysis included collapsing of questions, construction of scale scores and cross-tabulations.

Exhibit 1: Distribution of Completed Surveys and CalOptima Population by Language, Region and Age

Language	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
English	658	11.3%	55.5%
Spanish	715	12.3%	28.6%
Vietnamese	981	16.9%	10.3%
Korean	940	16.2%	1.4%
Farsi	743	12.8%	1.1%
Arabic	648	11.1%	0.6%
Chinese	731	12.6%	0.5%
Other	399	6.9%	2.0%

Region	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
Central	2,315	39.8%	51.5%
North	1,947	33.5%	32.4%
South	1,538	26.4%	15.1%
Out of County	15	0.3%	1.0%

Age	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
0–18 years old	1,665	28.6%	41.8%
19–64 years old	2,453	42.2%	47.2%
65 or older	1,697	29.2%	10.9%

KEY FINDINGS

Given the scope and depth of the study, the MHNA revealed many key findings, which will all be included in the final, comprehensive report. This Executive Summary shares five **key findings**, including related **bright spots** and **opportunities**. Bright spots are CalOptima and community-based resources that already serve to support health behaviors and outcomes. CalOptima can nurture, leverage and build upon these assets. **Opportunities** are areas that CalOptima and its partners can strengthen to positively impact the health and well-being of members.

KEY FINDING: SOCIAL DETERMINANTS OF HEATLH

Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

Given that Medi-Cal eligibility is income-based, it is not surprising that many CalOptima members struggle with economic insecurity. In fact, 55.7 percent of members receive some form of public benefits (Exhibit 2). Further, in the past six months, more than one-quarter of members indicated they needed help with food (32.4 percent), housing (24 percent), money to buy things they need (43.1 percent) and transportation (28.8 percent) (Exhibit 3). Economic stress and financial insecurity cause members and their families to make tradeoffs, such as living in more dense and overcrowded housing with limited space for play and exercise, buying cheaper but less healthy food, or not going to the doctor despite wanting to.

Exhibit 2: Percent of members who receive public benefits (n=5,117)

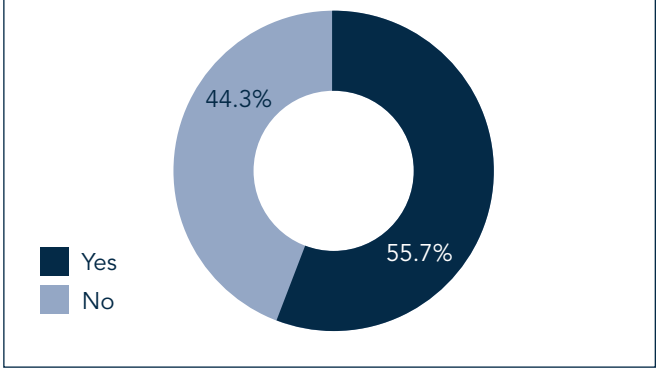
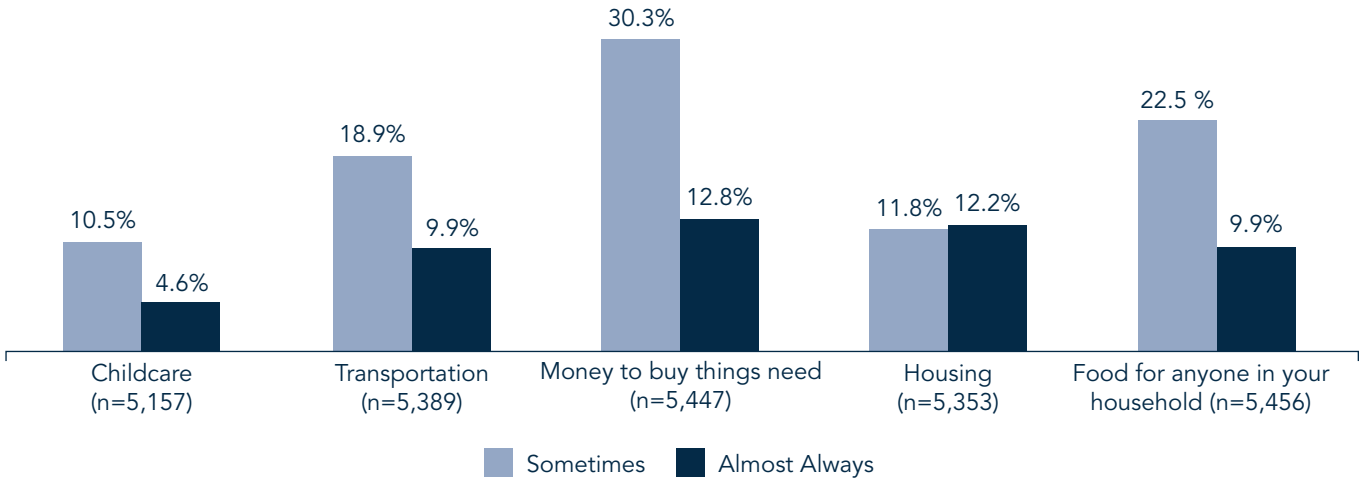


Exhibit 3: Percent of members who needed help with basic needs in the past six months



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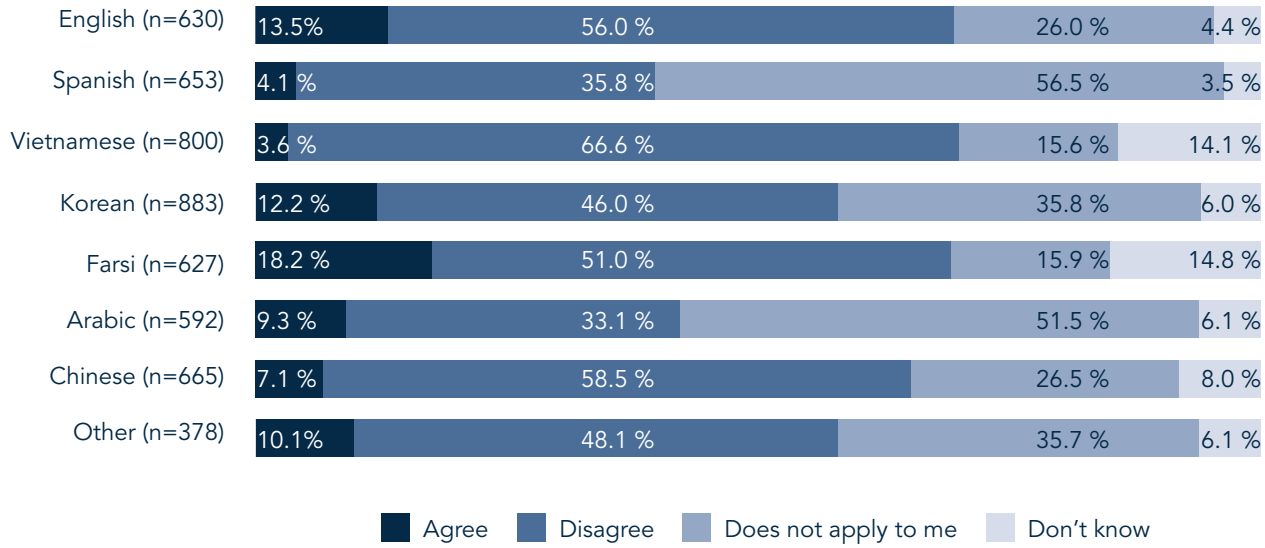
Social isolation negatively impacts the overall health and well-being of some CalOptima member populations. Social isolation is characterized by a lack of social supports and relationships. It occurs for many reasons, including language barriers, immigration status, age, ability and sexual orientation. In focus groups, members described how feelings of being disconnected from the community can lead to depression, lack of follow-up with health care or service providers, and negative health behaviors. In the survey, 10 percent of all respondents indicated that they felt lonely or isolated. Yet there were higher rates among certain populations, with loneliness and isolation affecting more speakers of English (13.5 percent), Korean (12.2 percent) and Farsi (18.2 percent) (Exhibit 4).

Exhibit 4: Percent of those who reported feeling lonely or isolated by language



Environmental factors also contribute to social isolation and other negative health behaviors, such as lack of physical activity. Focus group participants discussed feeling unsafe in their neighborhoods, which caused them to stay inside or to avoid nearby parks and/or other common spaces.

In addition, lack of affordable housing was a major concern to MHNA respondents, and it resulted in living in overcrowded households, neighborhoods with high crime rates, areas with poor indoor and outdoor air quality, and in the most extreme cases, homelessness.

Bright Spot: CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health a priority, not a lack of knowledge or concern.

Opportunity: CalOptima has already taken steps to strengthen the safety net for members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand this work would positively impact health outcomes in the long run. CalOptima can ensure that providers and community partners understand the social and economic issues that members face and how to adapt health care services accordingly.

KEY FINDING: MENTAL HEALTH

Lack of knowledge and fear of stigma are key barriers to using mental health services.

About 14 percent of members reported needing mental health services in the past year (Exhibit 5). However, local and national data suggest that the need for mental health services is likely underreported and underrecognized. Among those reporting a need, nearly 25 percent did not see a mental health specialist (Exhibit 6). Members did not seek mental health services for several reasons (Exhibit 7), including not knowing who to call or how to ask for help making an appointment (39.8 percent), not feeling comfortable talking about personal problems (37.5 percent) or concern that someone would find out they had a problem (26.1 percent). These factors, along with data gathered from key stakeholder interviews and focus groups, reflect a fear of stigma associated with seeking mental health services.

Exhibit 5: Percent of members who indicated they needed to see a mental health specialist (n=5,723)

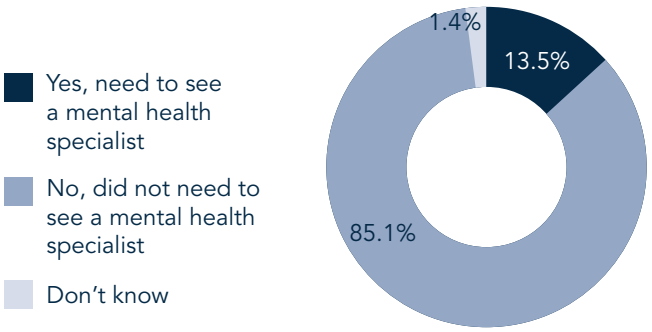
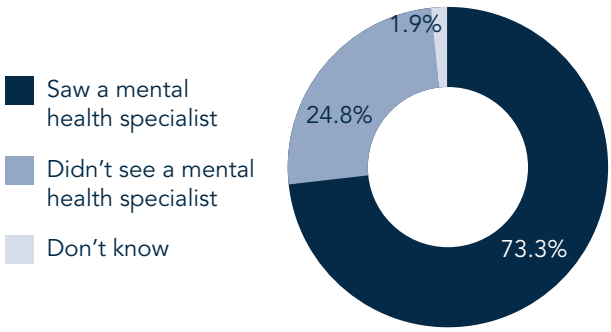
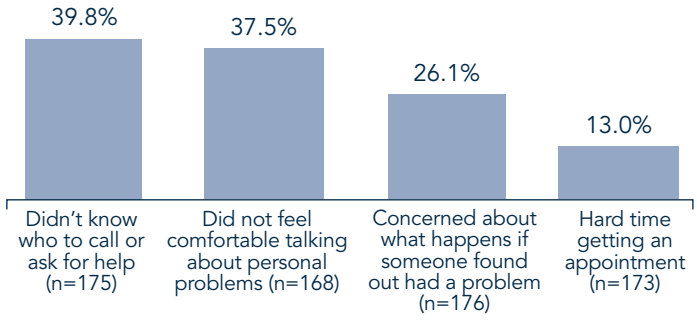


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



Fear of stigma is more prevalent among certain language groups. For example, Chinese-speaking members were more likely to indicate discomfort talking about personal problems and concern about what others might think if they found out about a mental illness than other language groups, followed by Korean-, Vietnamese- and English-speaking members. Conversations with community members and service providers offered cultural context for these findings as many stakeholders described prevalent feelings of shyness, avoidance and shame around discussing mental health issues, let alone seeking care.

Exhibit 7: Reasons why members (who needed to see a mental health specialist but) didn't get services



Bright Spot: CalOptima provides access to mental health services, which meets a clearly established need. Although members needing mental health services do not always connect with providers, many do not do so because of a lack of knowledge, an issue that can be addressed through strengthened connections with existing systems.

Opportunity: Although mental health services are covered by CalOptima, fear of stigma may prevent members from seeking services. This presents an opportunity for CalOptima to continue to provide culturally relevant education around mental health to improve understanding of available services and to address fear of stigma many people face. Community partners with deep knowledge of specific cultural communities are eager to offer support that would increase the use of mental health services.

KEY FINDING: PRIMARY CARE

Most members are connected to primary care, but barriers can make it challenging to receive timely care.

The majority of CalOptima members indicated that they are connected to at least one primary care doctor (82.6 percent), and most go to a doctor's office (69.2 percent) or clinic/health center (18.1 percent) when they need medical attention (Exhibits 8 and 9). However, navigating the health care system can be challenging, and significant barriers make it difficult for people to seek or follow through with care when needed.

Exhibit 8: Percent who report at least one person as their doctor (n=5,749)

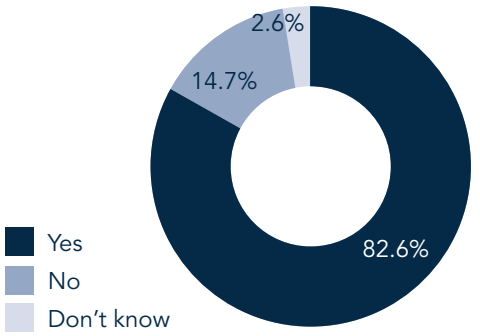
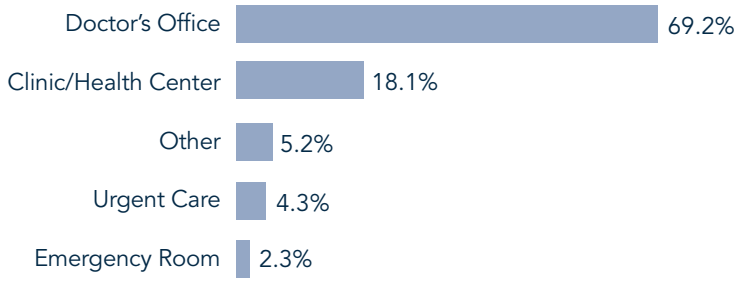


Exhibit 9: Where respondents go to see their doctor (n=5,743)

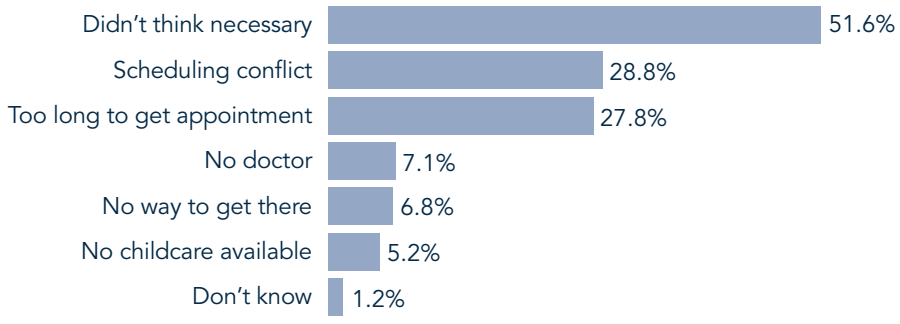


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited hours of operation and inefficiency of public transportation, can make it difficult for people to receive care when needed. When asked why they don't make an appointment to see a doctor, 27.8 percent of CalOptima members indicated that it takes too long to get an appointment while 51.6 percent of members did not think it was necessary to make an appointment (Exhibit 10).

Bright Spot: CalOptima members have access to more than 1,500 primary care providers and 6,200 specialists, as well as 14 different health networks. And staff members are dedicated to continually engaging and educating these providers and networks to ensure they are ready to deliver the care needed by members.

Opportunity: The challenge of maintaining a robust provider network never goes away, and CalOptima must carefully monitor members' access to care. The provider community may be ready to embrace innovations that enhance access, such as extended hours, weekend operations or telemedicine visits, to expand the options for members.

Exhibit 10: Reasons why members don't make an appointment to see doctor (n=4,598)[1]



KEY FINDING: PROVIDER ACCESS

Members are culturally diverse and want providers who both speak their language and understand their culture.

CalOptima members hail from around the globe, reflecting the rich diversity of Orange County's population. In total, 40.3 percent of respondents were born outside of the U.S. and 23.6 percent indicated that they don't speak English well (Exhibits 11 and 12). Among non-English speakers, more than 50 percent were born outside of the United States and many are still acculturating to life in the U.S. This presents challenges when finding a well-paying and fulfilling job, safe and affordable housing, and healthy and familiar food. It also affects the ways members interact with the health care system. In fact, those born outside of the U.S. were significantly less likely to have a doctor and more likely to report feeling lonely or isolated.

Exhibit 11: How well members speak English (n=5,549)

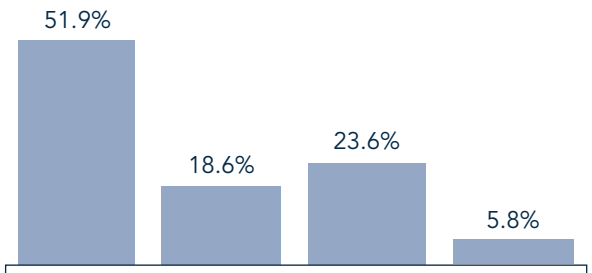
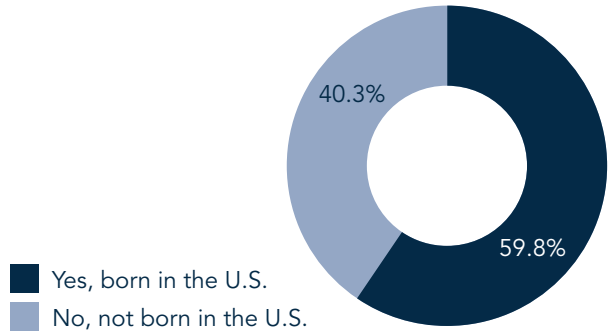


Exhibit 12: Percent of members who were born in the United States (n=5,599)



Further, they report having to adapt to new ways of receiving medical care. Some focus group participants shared that they did not understand why they must wait so long to see a doctor, as it is not this way in their country of origin. Others shared that cultural beliefs and practices made them uncomfortable and often unwilling to see a physician of the opposite gender. In addition, members and key stakeholders indicated that it can be challenging to seek medical care from providers who do not speak members' preferred language, which leads to issues with communication and comfort level. Although many stakeholders highlighted the availability of translation or interpretation services, such services do not always meet members' needs, especially when limited by short appointment times and when sharing sensitive information.

Bright Spot: CalOptima provides services and resources to members in seven languages[2] and can connect members to translation and interpretation services in any language when needed. Members appreciate that CalOptima recognizes the importance of providing care in familiar languages, and they also highly value providers who are sensitive to the cultural norms and practices of their homeland.

Opportunity: CalOptima has an opportunity to build its existing resources and deepen cultural competence of providers and services. CalOptima can engage partners in culturally focused community-based organizations to tailor and implement trainings for providers around specific populations. Trainings can build language and sensitivity skills and increase knowledge in areas such as ethnopharmacology (variations in medication responses in diverse ethnic populations). This can strengthen the workforce and improve member/provider interactions overall.

KEY FINDING: DENTAL CARE

Many members are not accessing dental care and are often unsure about what dental services are covered.

The gap in dental health care is striking and pronounced; 38.2 percent of members indicated they had not seen a dentist within the past 12 months (Exhibit 13). Among those individuals, 41 percent cited cost as the main reason they did not see a dentist (Exhibit 14). Members expressed confusion about dental care benefits available to them via Medi-Cal/Denti-Cal, and they said they would be more likely to seek out a dentist if they knew some of their visits were covered.

Bright Spot: Members in all CalOptima programs are eligible for routine dental care through Denti-Cal, and members in OneCare and OneCare Connect have access to supplemental dental care as well. Better yet, for 2018, California restored additional Denti-Cal benefits, expanding the covered services even further. The challenge is ensuring that members know about these benefits and then actually obtain the services.

Opportunity: To boost the number of members receiving dental care, CalOptima will have to first raise awareness about the availability of services and correct misperceptions that dental care comes at a cost. Further, to remove barriers to care and expand access, the community may embrace the use of alternative providers, such as mobile dental clinics, or the option of co-located dental and medical services.

Exhibit 13: When members last saw a dentist (n=5,685)

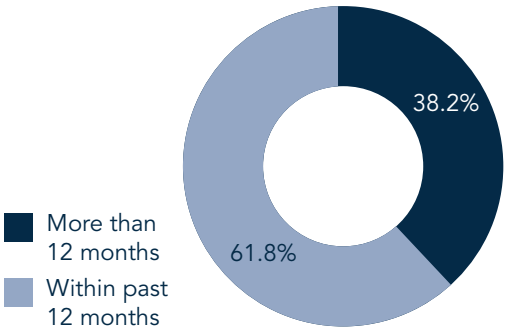
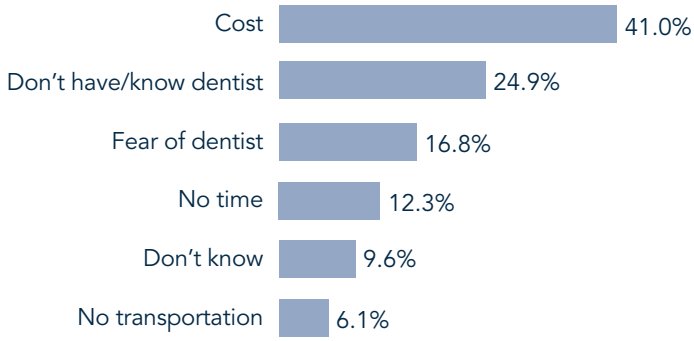


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3] [4]



Endnotes

[1] Members could choose multiple answers; thus, the total does not equal 100 percent.

[2] CalOptima provides bilingual staff, interpreter services, health education and enrollment materials in seven languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.

[3] Members could choose multiple answers; thus, the total does not equal 100 percent.

[4] Only reported those who have not seen a dentist within the past 12 months.

January 2018

CalOptima Member Survey Analysis:

Unweighted Estimates by Language, Region, and Age

DRAFT

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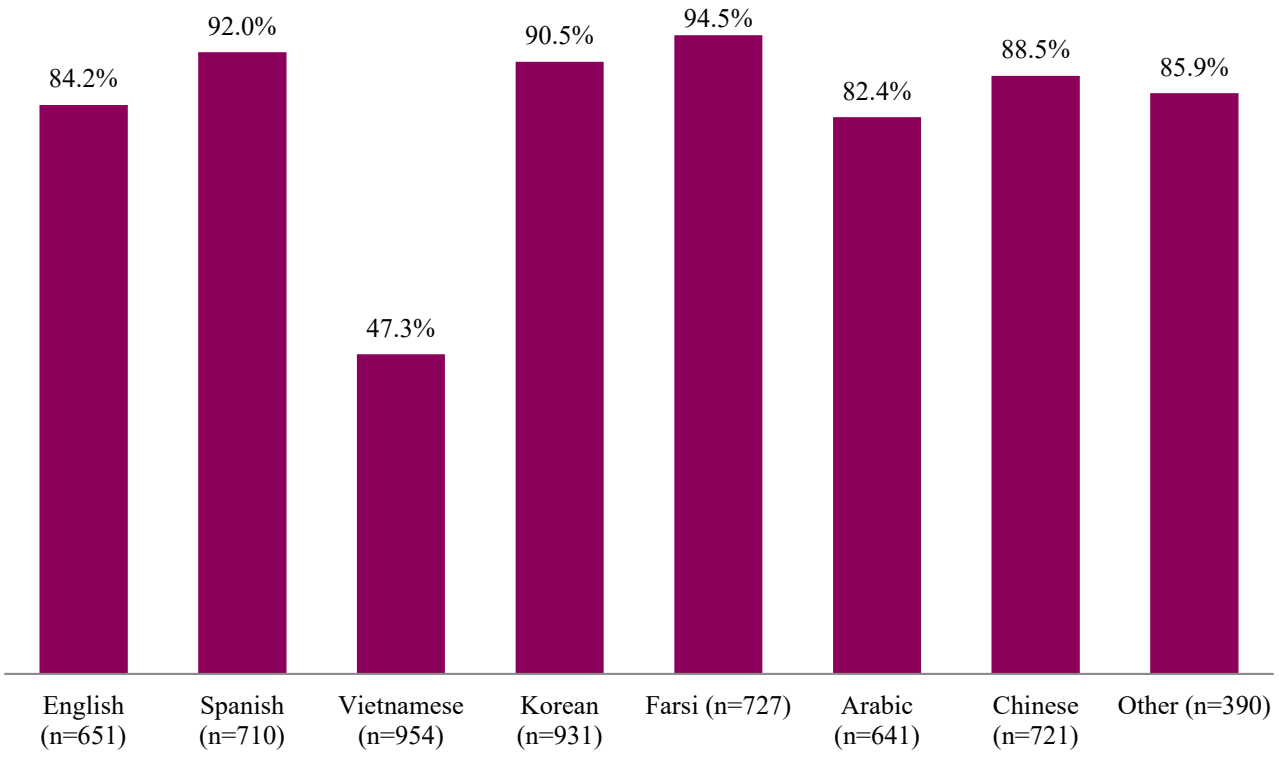
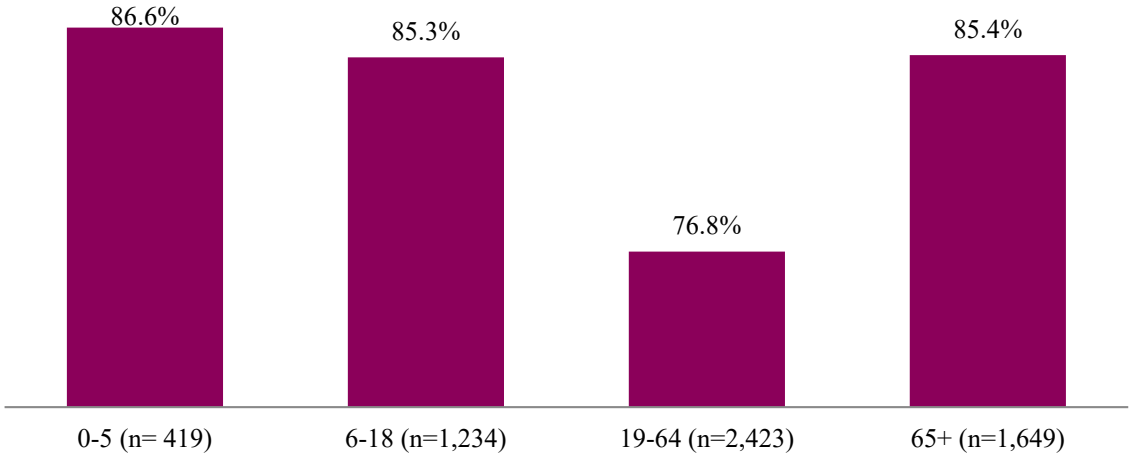
Navigating the Healthcare System

Exhibit 1. Percent who report at least one person as their doctor[1]

CalOptima language:



Age Group:



[1] An issue was identified with the Vietnamese translation of this question. Therefore, results likely misrepresent percentage of Vietnamese members who have a doctor.

Region:

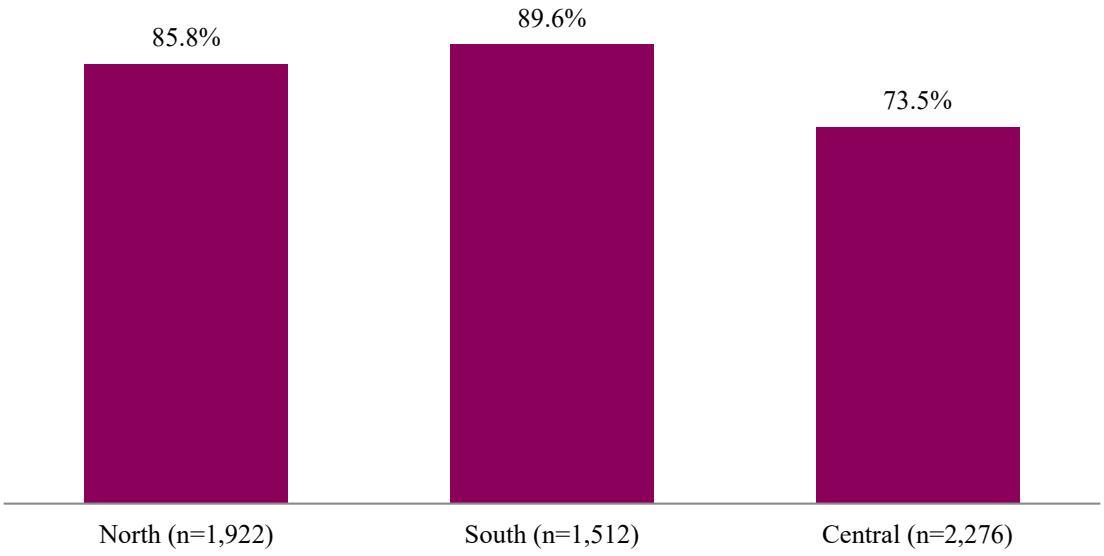


Exhibit 2. Where respondents go to see their doctor

CalOptima language:

CalOptima Language	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
English	71.8%	11.9%	2.0%	6.6%	0.5%	6.4%	0.8%	653
Spanish	59.7%	32.3%	3.4%	1.0%	0.3%	3.1%	0.1%	699
Vietnamese	86.3%	12.0%	0.1%	0.2%	0.0%	1.0%	0.3%	965
Korean	87.8%	4.3%	0.9%	1.1%	0.7%	4.1%	1.2%	938
Farsi	84.0%	6.5%	3.0%	0.8%	0.1%	5.0%	0.5%	737
Arabic	65.3%	15.8%	4.6%	5.4%	0.3%	8.0%	0.5%	625
Chinese	77.2%	11.4%	0.3%	0.8%	0.4%	6.6%	3.3%	727
Other	72.2%	12.6%	1.5%	3.0%	0.0%	9.6%	1.0%	396

Age Category:

CalOptima Age Category	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	68.4%	19.1%	1.9%	2.7%	0.2%	7.2%	0.5%	414
6-18 (Children)	73.0%	16.5%	1.6%	3.0%	0.4%	4.4%	1.0%	1,224
19-64 (Adults/MCE)	73.1%	14.2%	2.6%	2.7%	0.5%	5.5%	1.4%	2,425
65+ (Older Adults)	87.5%	6.8%	0.8%	0.4%	0.1%	4.1%	0.4%	1,677

Region:

CalOptima Region	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
North	74.4%	13.8%	1.7%	3.4%	0.4%	5.4%	1.0%	1,920
South	80.4%	7.9%	2.0%	1.4%	0.5%	6.4%	1.4%	1,521
Central	76.8%	15.5%	1.8%	1.4%	0.2%	3.6%	0.6%	2,284

Exhibit 3. Reasons why members go somewhere other than their doctor when they need medical attention

CalOptima language:

CalOptima Language	I don't have a doctor	It is easier for me to get to the emergency room or urgent care than my doctor's office	It's hard to get an appointment with my doctor	Other	Don't know	n
	%	%	%	%	%	
English	7.4%	26.5%	21.4%	40.7%	4.0%	570
Spanish	7.5%	22.2%	20.1%	37.9%	12.4%	523
Vietnamese	3.1%	31.8%	16.8%	46.2%	2.1%	584
Korean	11.5%	22.7%	27.8%	37.6%	0.4%	687
Farsi	3.1%	15.4%	22.7%	58.8%	0.0%	422
Arabic	5.2%	40.6%	25.5%	28.0%	0.7%	554
Chinese	9.1%	26.8%	14.6%	47.9%	1.6%	549
Other	6.0%	24.9%	16.7%	50.8%	1.6%	317

Age Category:

Age Category	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
0-5 (Children)	4.5%	34.4%	25.4%	29.3%	6.5%	355
6-18 (Children)	5.2%	27.7%	24.0%	36.2%	6.9%	986
19-64 (Adults/MCE)	9.2%	26.0%	23.7%	39.9%	1.3%	1,789
65+ (Older Adults)	4.5%	34.4%	25.4%	29.3%	6.5%	1,076

Region:

Region	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
North	7.4%	27.1%	25.2%	38.4%	1.9%	1,501
South	6.7%	23.1%	20.5%	47.2%	2.5%	1,052
Central	6.3%	28.9%	17.6%	43.2%	4.0%	1,639

Exhibit 4. When do members make an appointment to see doctor[2]

CalOptima Language:

CalOptima Language	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
English	75.8%	77.2%	51.8%	1.1%	4.2%	650
Spanish	77.7%	76.2%	36.9%	0.8%	4.5%	713
Vietnamese	76.0%	74.7%	39.7%	0.1%	1.7%	973
Korean	81.3%	75.2%	47.4%	0.4%	0.6%	938
Farsi	87.4%	80.0%	65.1%	1.8%	3.7%	736
Arabic	82.5%	40.4%	30.9%	0.5%	1.4%	644
Chinese	80.3%	73.6%	48.6%	1.5%	1.2%	727
Other	70.1%	82.0%	51.1%	1.5%	4.6%	395

Age Category:

Age Category	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
0-5 (Children)	86.4%	76.9%	41.9%	0.7%	1.2%	420
6-18 (Children)	81.8%	73.2%	39.9%	0.5%	2.2%	1,236
19-64 (Adults/MCE)	78.0%	67.9%	47.3%	1.1%	2.3%	2,433
65+ (Older Adults)	77.8%	77.4%	50.0%	0.9%	3.4%	1,687

[2] **Members were allowed to choose multiple answers; thus, the total does not equal 100%.**

Region:

Region	When Sick	Check-Up	Specialist Needed	Don't Know	Other	n
	%	%	%	%	%	
North	78.2%	70.5%	43.6%	0.9%	2.3%	1,938
South	83.3%	75.9%	55.9%	1.3%	2.8%	1,527
Central	77.7%	72.0%	41.8%	0.5%	2.5%	2,296

Exhibit 5. Reasons why members don't make an appointment to see doctor[3]

CalOptima language:

CalOptima Language	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
English	7.8%	6.7%	28.0%	27.6%	5.2%	54.0%	1.8%	554
Spanish	6.3%	6.5%	20.8%	27.4%	5.2%	53.2%	0.8%	504
Vietnamese	2.3.%	7.0%	50.9%	24.8%	4.1%	42.8%	0.0%	725
Korean	11.7%	4.1%	48.4%	39.7%	3.8%	31.5%	0.0%	677
Farsi	5.7%	19.5%	24.9%	45.1%	6.9%	33.3%	0.0%	406
Arabic	2.7%	7.0%	28.2%	42.6%	2.1%	37.1%	0.0%	561
Chinese	7.2%	9.6%	29.8%	24.8%	2.2%	51.0%	0.9%	541
Other	4.1%	8.8%	25.0%	29.1%	1.7%	56.8%	0.0%	296

[3] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Age Category:

Age Category	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	4.6%	6.5%	32.8%	35.9%	10.5%	43.7%	0.0%	323
6-18 (Children)	4.8%	4.5%	38.2%	32.8%	3.9%	43.4%	0.1%	990
19-64 (Adults /MCE)	7.8%	7.4%	36.3%	34.5%	4.2%	39.5%	0.8%	1,933
65+ (Older Adults)	4.5%	13.3%	26.1%	26.9%	1.3%	53.2%	0.3%	1,018

Region:

Region	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%			
North	7.6%	7.7%	36.3%	35.0%	3.3%	40.5%	0.3%	1,521
South	6.3%	10.5%	27.5%	35.8%	4.8%	45.7%	0.6%	1,019
Central	4.6%	6.9%	35.9%	28.1%	4.0%	46.1%	0.5%	1,712

Exhibit 6. When do members make an appointment to see a specialist[4]

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
English	76.0%	26.5%	63.5%	638
Spanish	71.9%	30.5%	60.7%	679
Vietnamese	70.3%	24.4%	56.7%	949
Korean	69.1%	27.1%	45.2%	877
Farsi	78.6%	31.4%	55.7%	688
Arabic	68.9%	16.3%	42.5%	631
Chinese	66.0%	35.6%	45.4%	694
Other	79.2%	26.8%	59.9%	384

Age Category:

Age Category	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
0-5 (Children)	71.1%	28.4%	53.8%	394
6-18 (Children)	67.7%	25.7%	52.6%	1,172
19-64 (Adults/MCE)	71.5%	25.2%	54.5%	2,328
65+ (Older Adults)	75.7%	31.3%	51.7%	1,646

[4] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Region:

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
North	69.3%	27.7%	50.6%	1,857
South	74.3%	28.3%	52.9%	1,453
Central	72.6%	26.6%	55.5%	2,216

Exhibit 7. Reasons why members don't make an appointment to see specialist[5]

CalOptima Language:

CalOptima Language	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
English	19.5%	8.0%	20.4%	27.0%	41.1%	548
Spanish	7.9%	5.5%	12.0%	20.2%	46.4%	560
Vietnamese	11.3%	9.3%	37.8%	30.7%	33.4%	724
Korean	14.2%	12.5%	32.6%	41.5%	27.6%	696
Farsi	13.9%	14.3%	15.2%	37.6%	24.5%	474
Arabic	9.9%	6.9%	21.5%	47.1%	25.6%	577
Chinese	11.9%	14.6%	17.6%	25.4%	42.6%	556
Other	15.6%	12.6%	16.5%	27.2%	39.2%	334

Age Category:

Age Category	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
0-5 (Children)	10.8%	8.1%	22.8%	33.5%	41.0%	334
6-18 (Children)	12.1%	7.9%	27.2%	32.1%	35.9%	1,019
19-64 (Adults/MCE)	13.7%	9.8%	24.9%	35.5%	31.6%	1,953
65+ (Older Adults)	12.6%	13.8%	16.3%	27.6%	37.0%	1,163

[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Region:

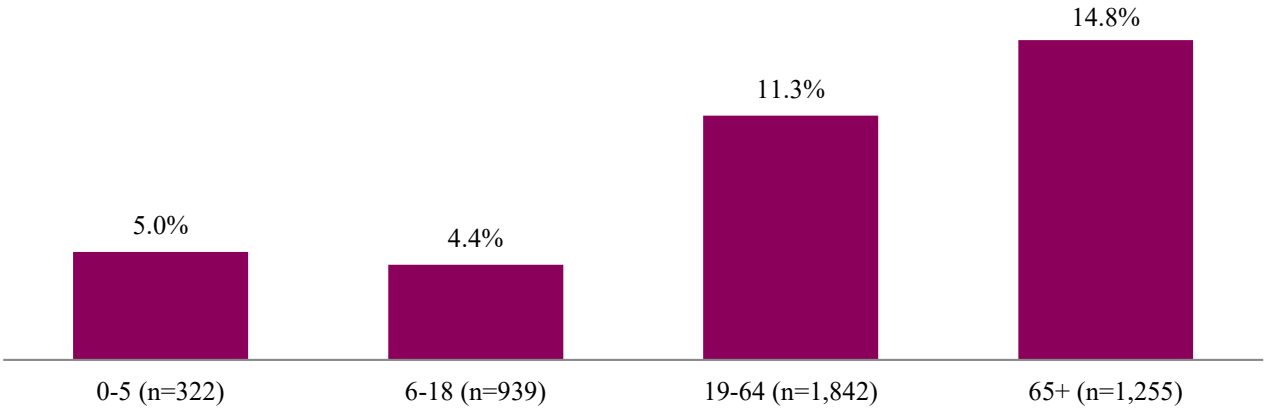
Region	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
North	14.0%	11.3%	24.8%	35.9%	31.1%	1,567
South	13..6%	11.3%	17.5%	33.6%	35.9%	1,097
Central	11.4%	8.8%	24.9%	28.9%	37.2%	1,792

Exhibit 8. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor

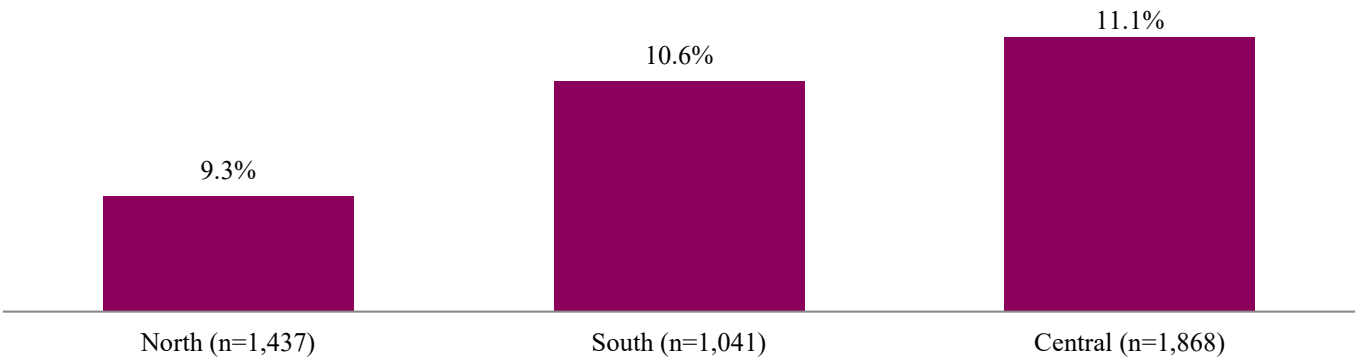
CalOptima language:



Age Category:



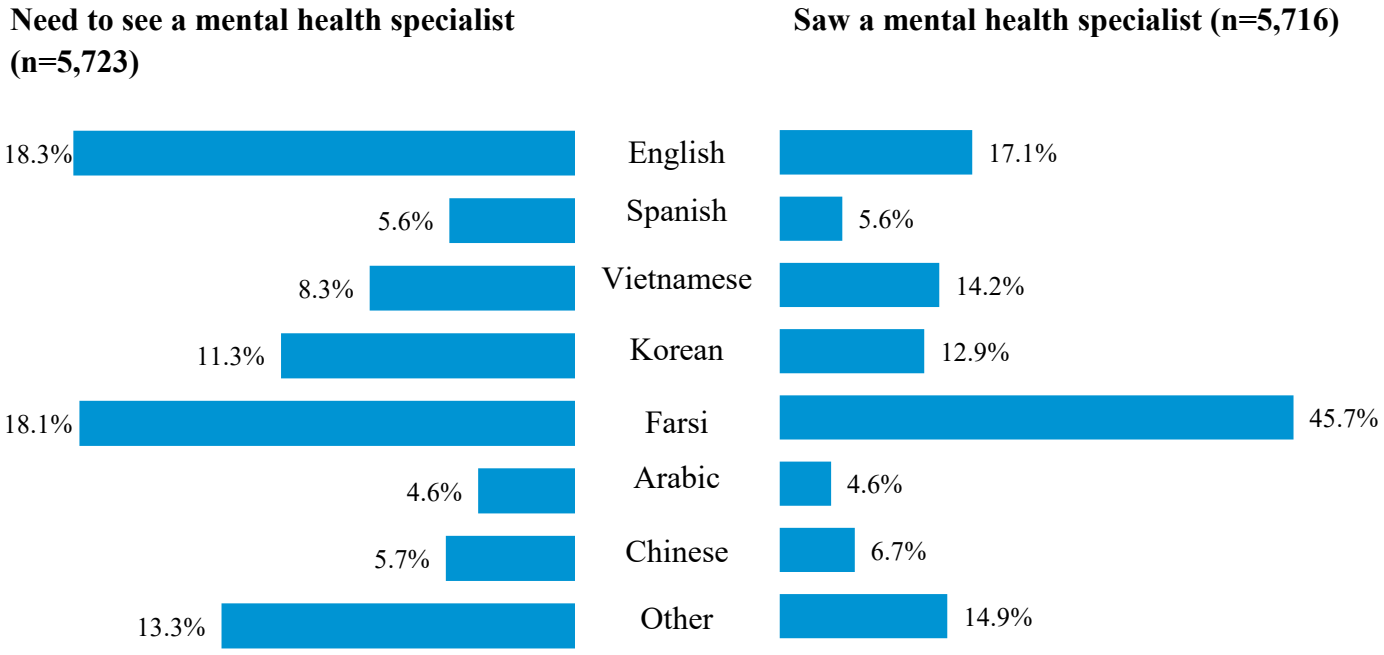
Region:



Social and Emotional Well-Being

Exhibit 9. Members who needed to see compared to those who saw a mental health specialist in the last 12 months[6]

CalOptima Language:

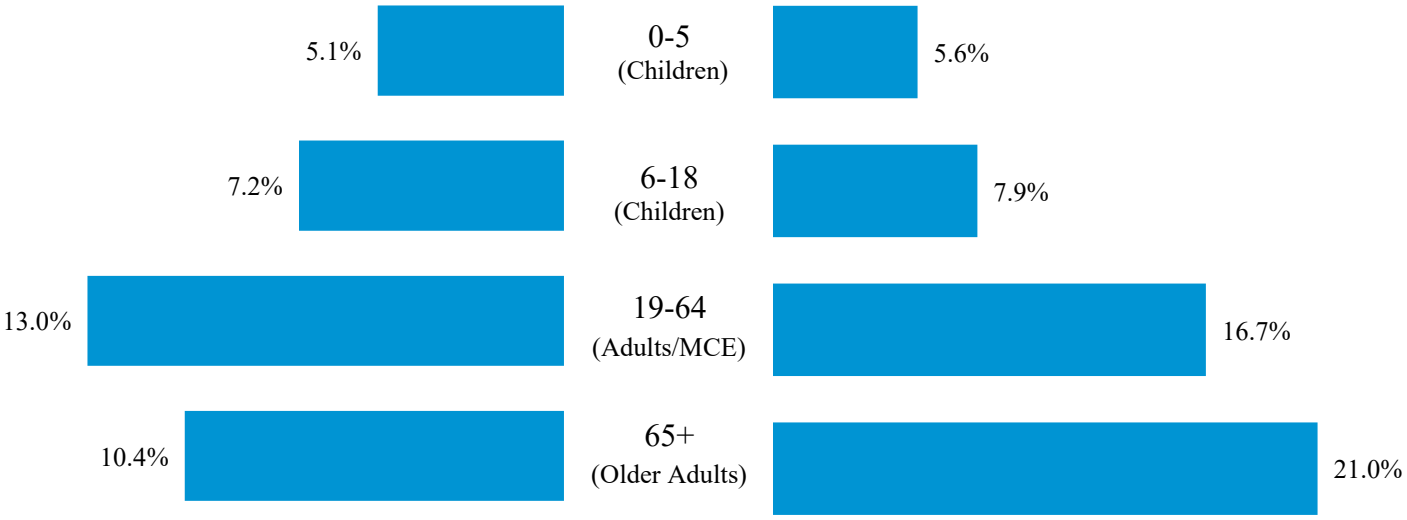


[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

Age Category:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)



Region:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)

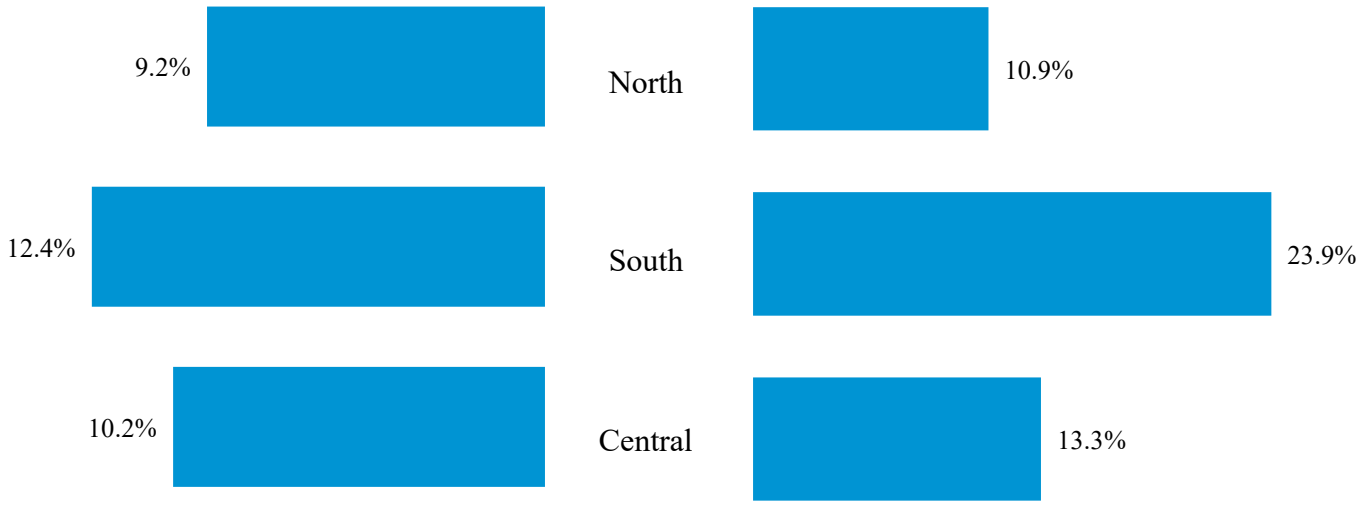
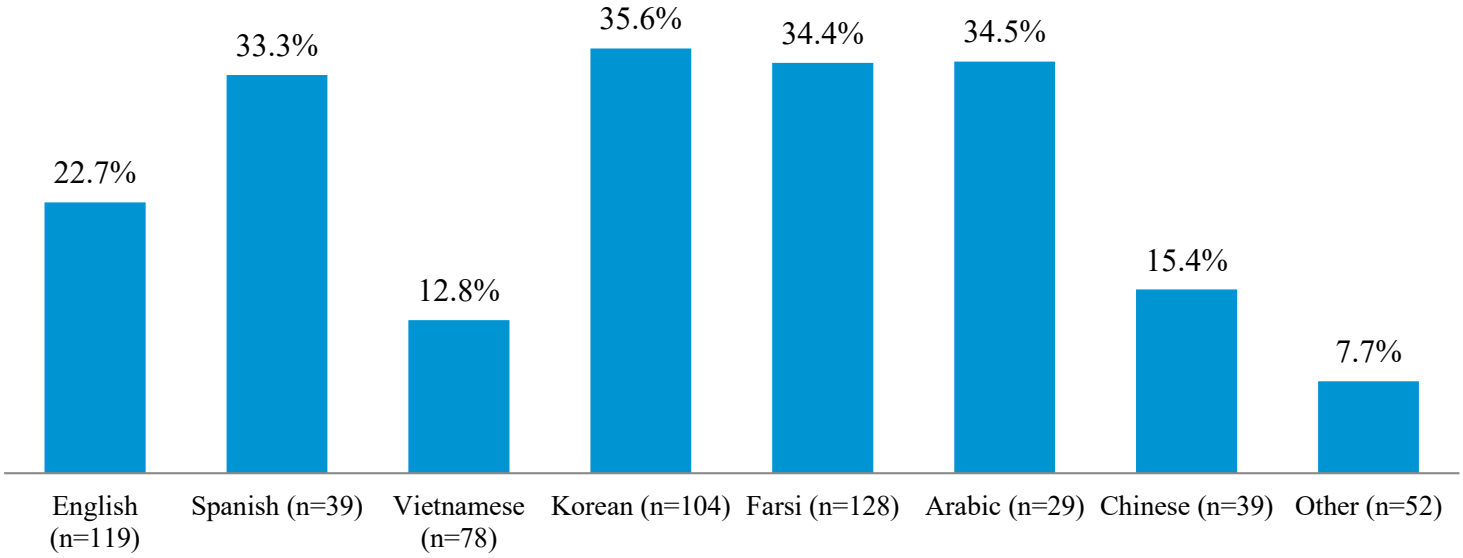
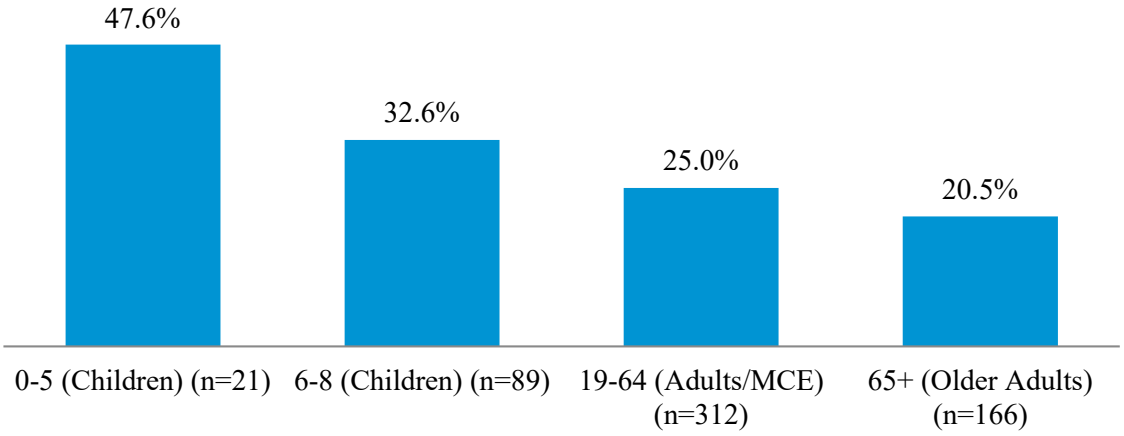


Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist

CalOptima Language:



Age Category:



Region:

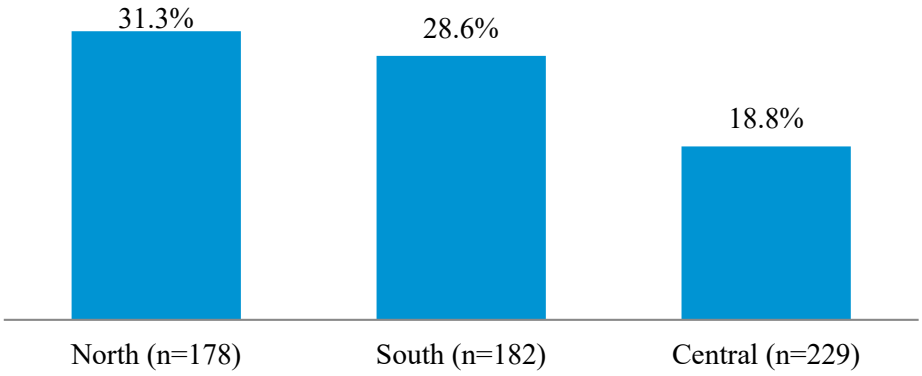
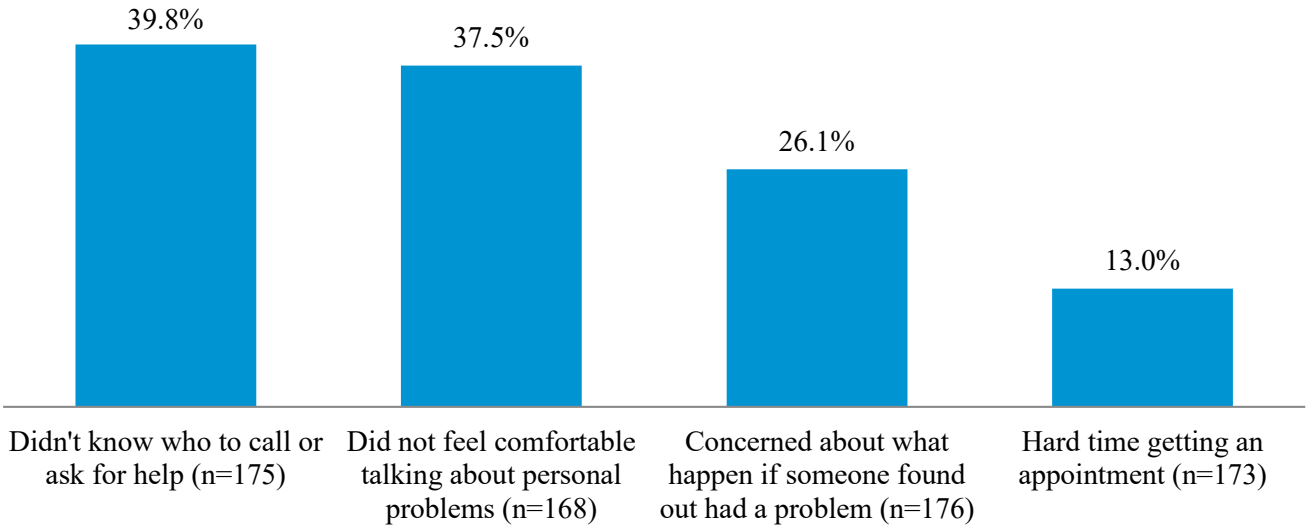


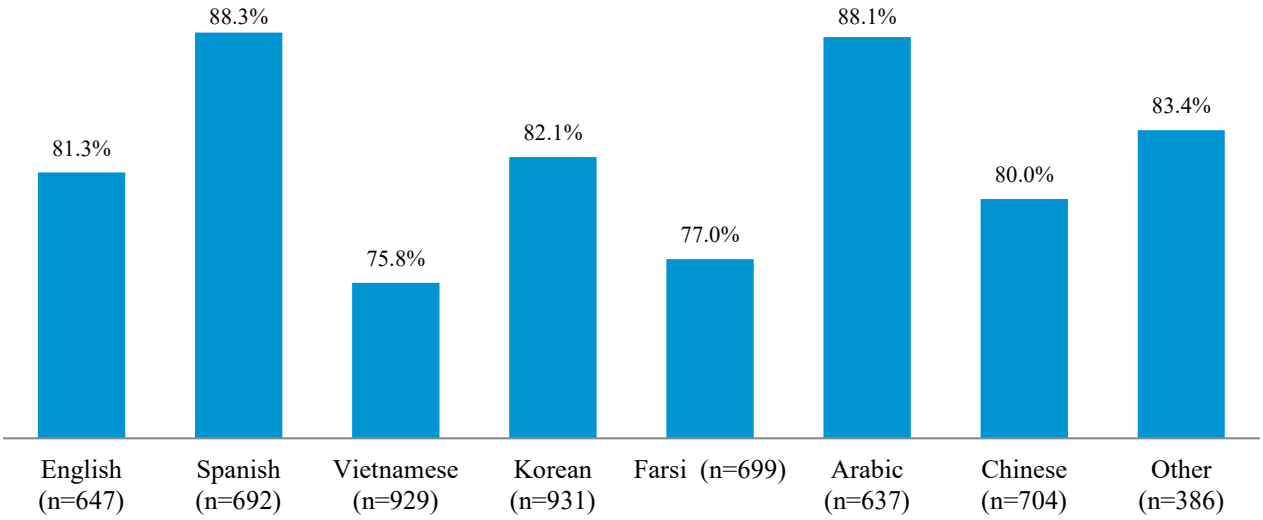
Exhibit 11. Reasons why members didn't see mental health specialist[7]



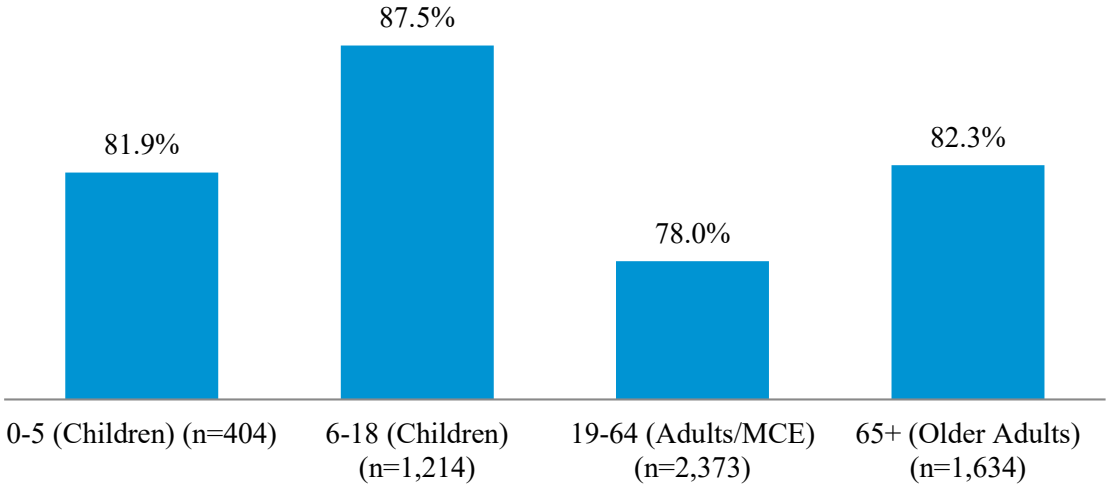
[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

Exhibit 12. Percent of members who can share their worries with family members

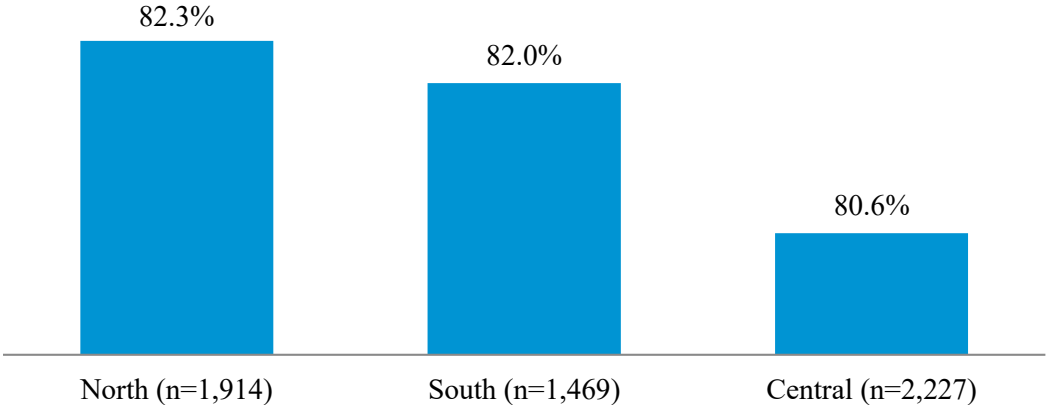
CalOptima language:



Age Category:



Region:

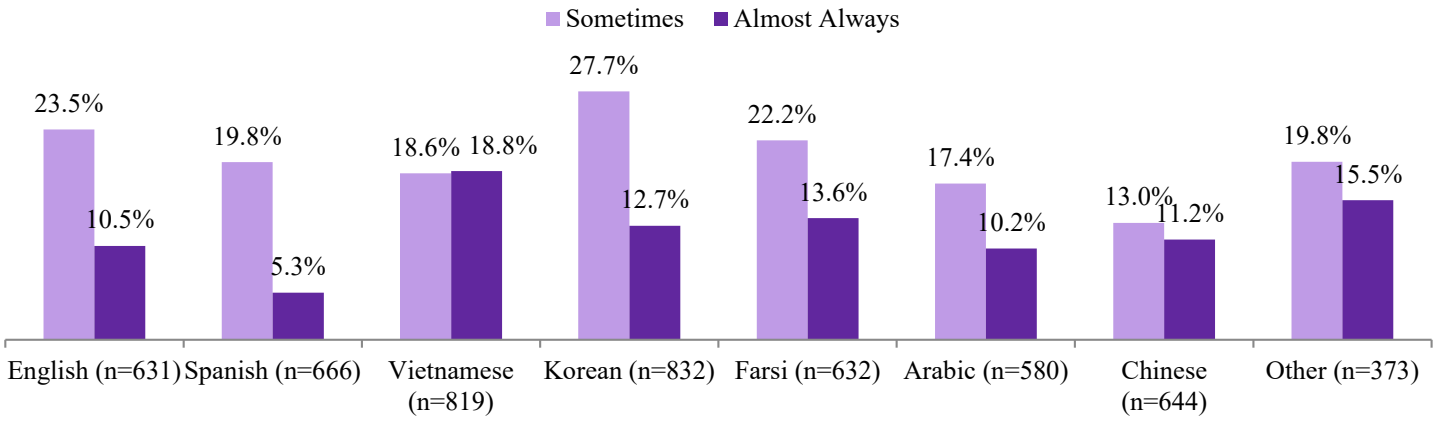


Social Determinants of Health

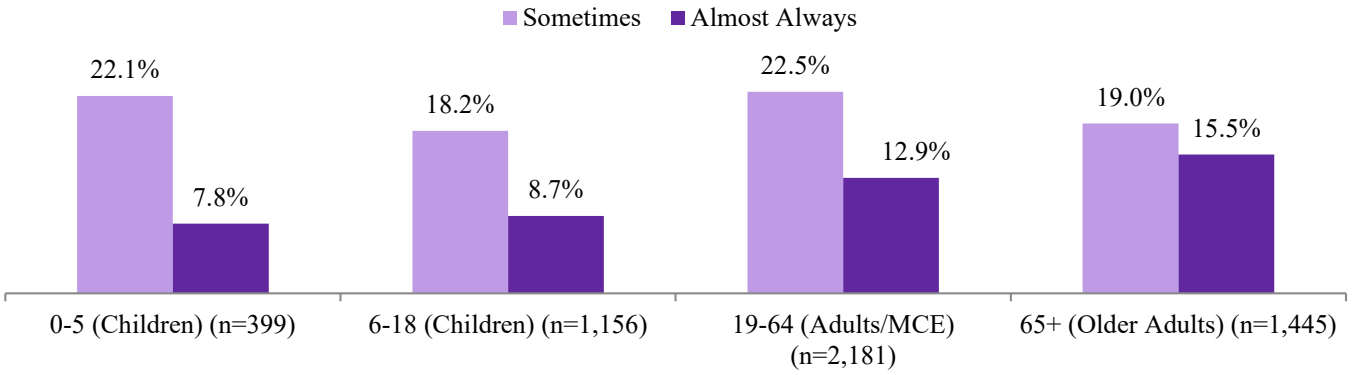
Exhibit 13. Needed help with the following in the past 6 months:

Food for anyone in your household:

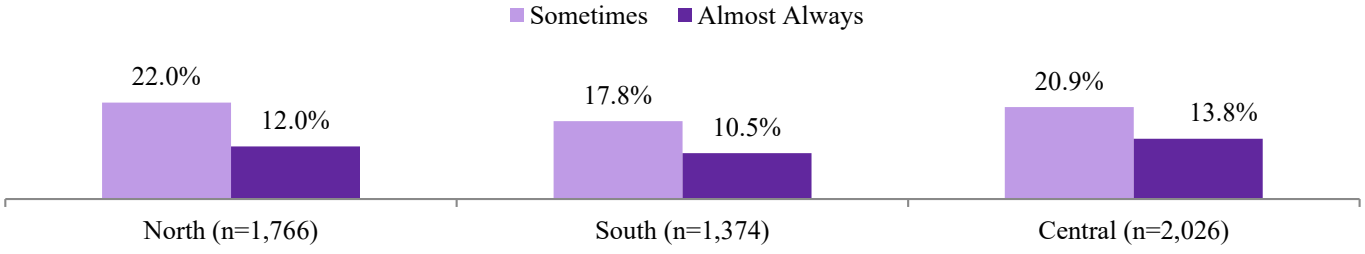
CalOptima language:



Age Category:

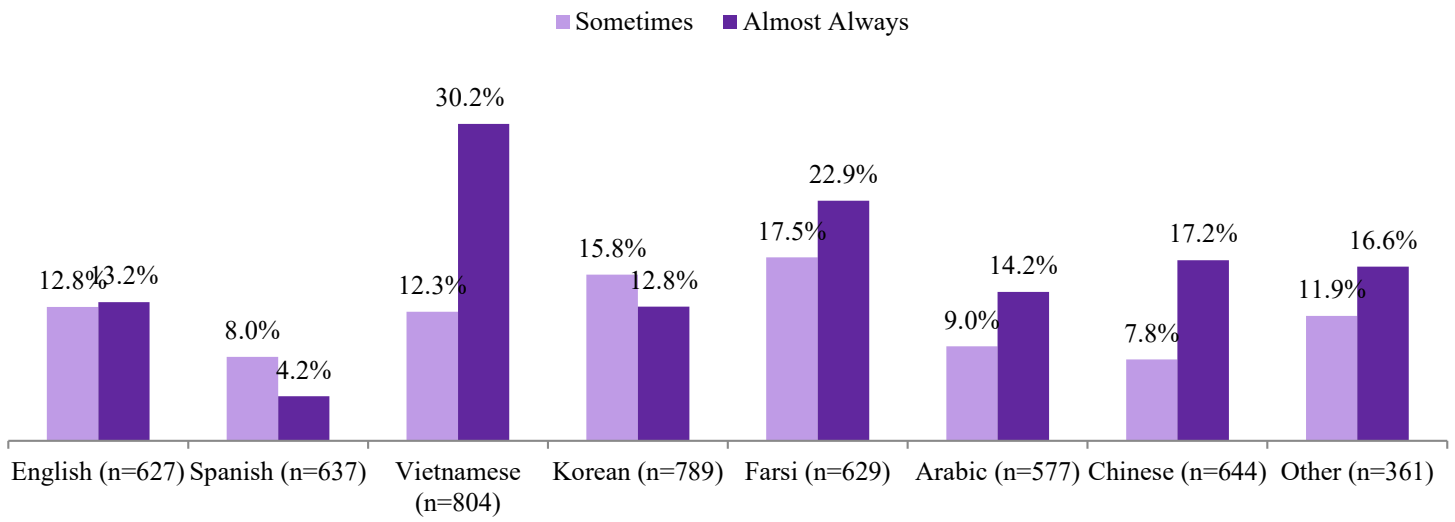


Region:

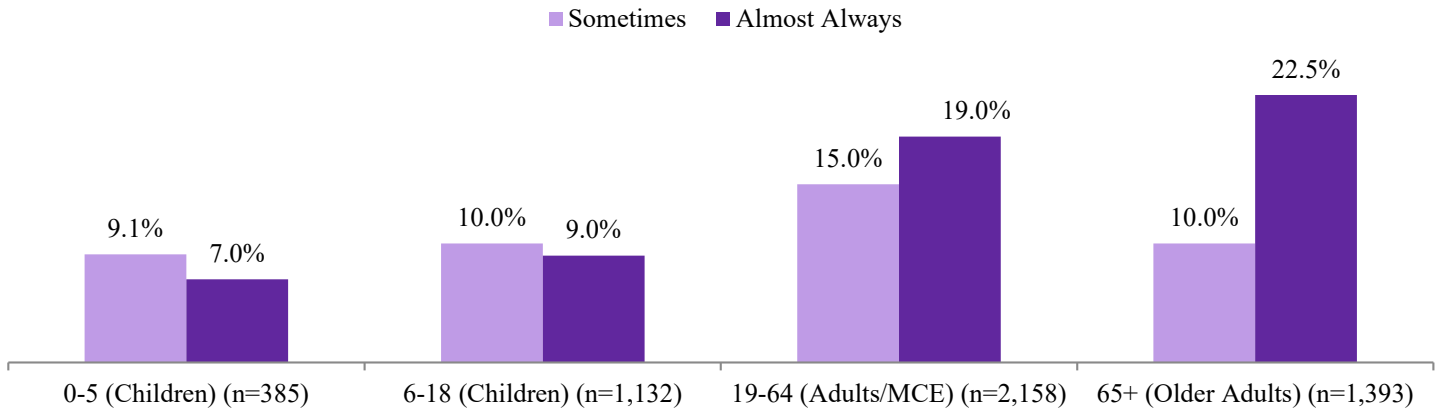


Housing:

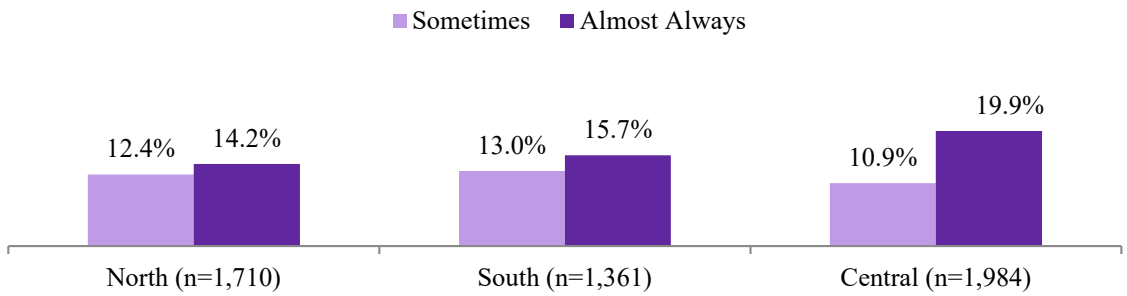
CalOptima language:



Age Category:

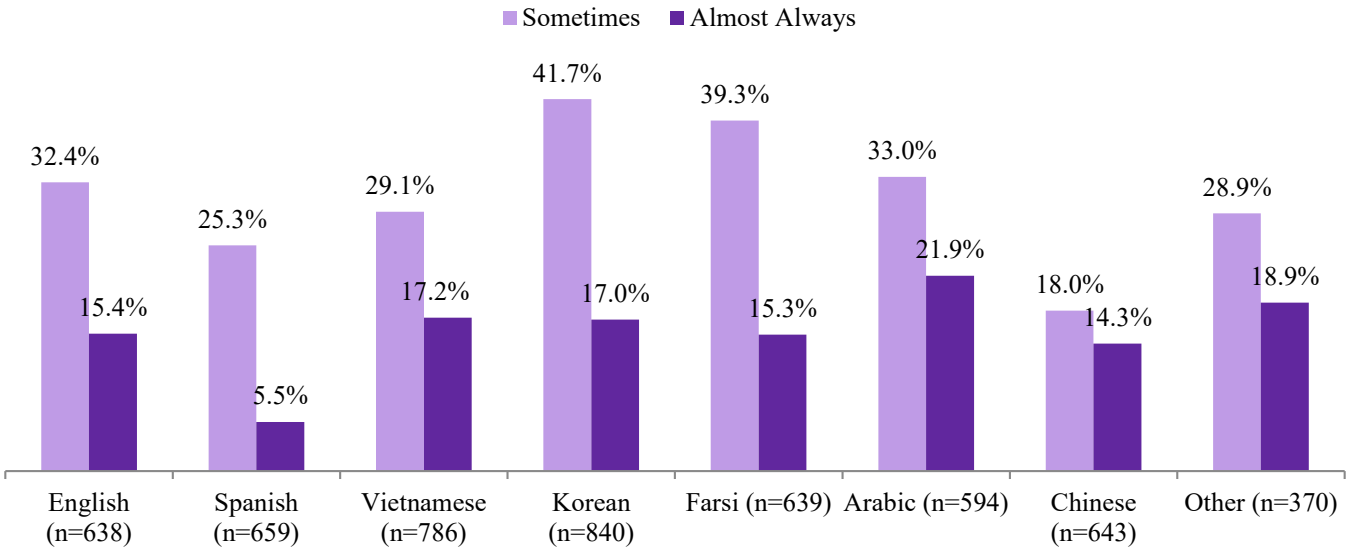


Region:

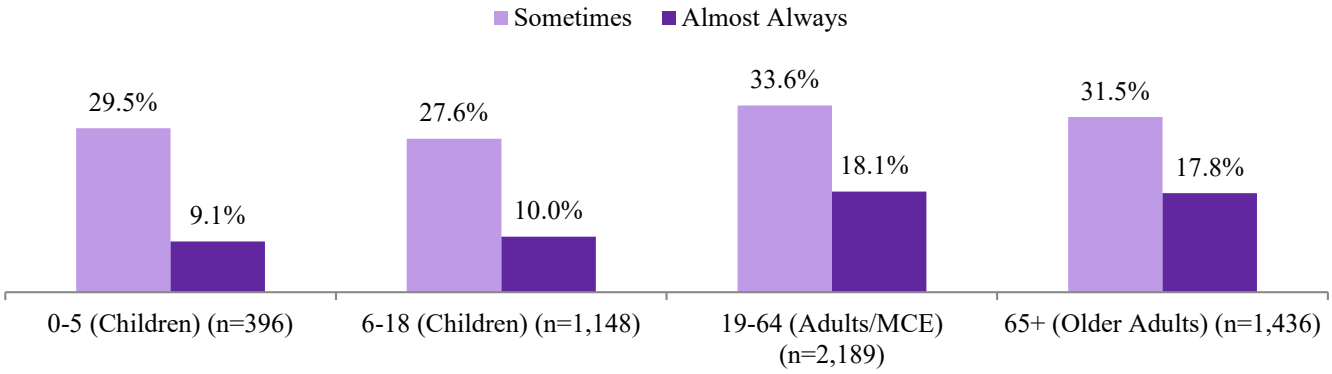


Money to buy things need:

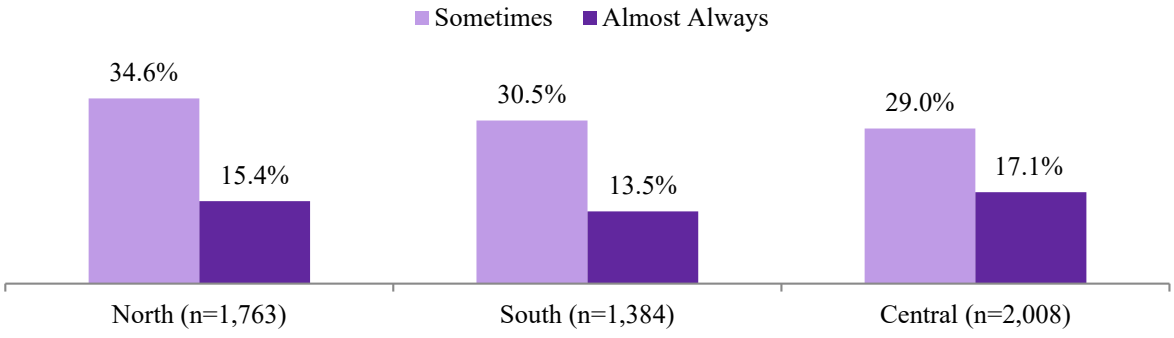
CalOptima language:



Age Category:

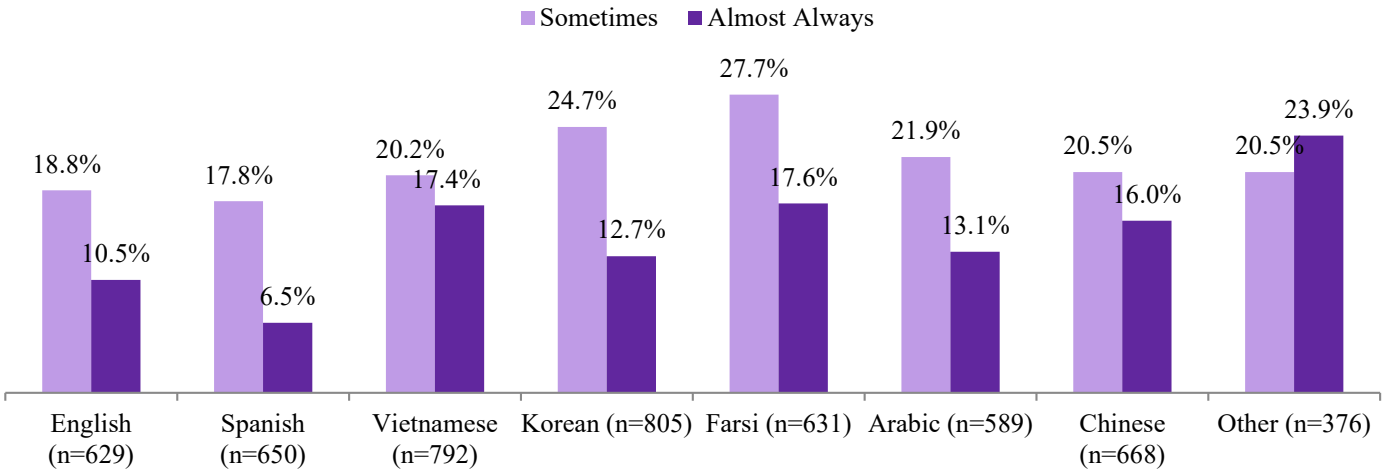


Region:

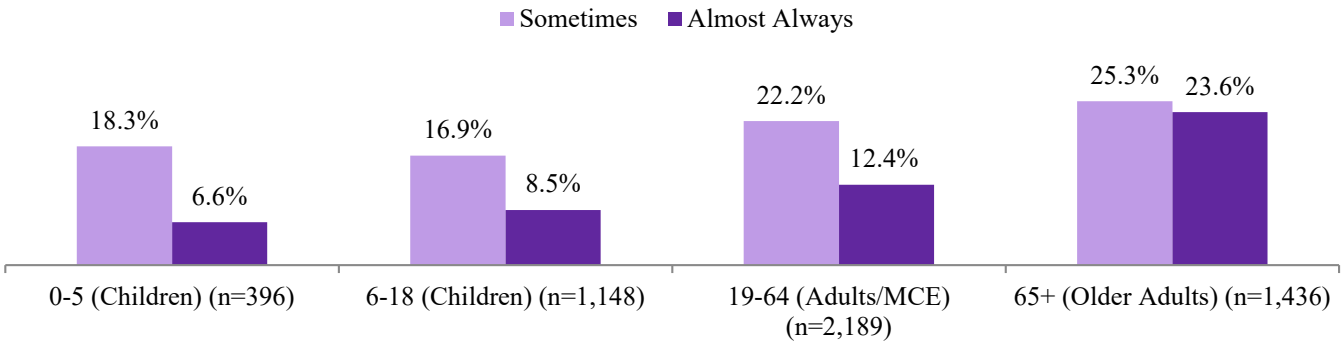


Transportation:

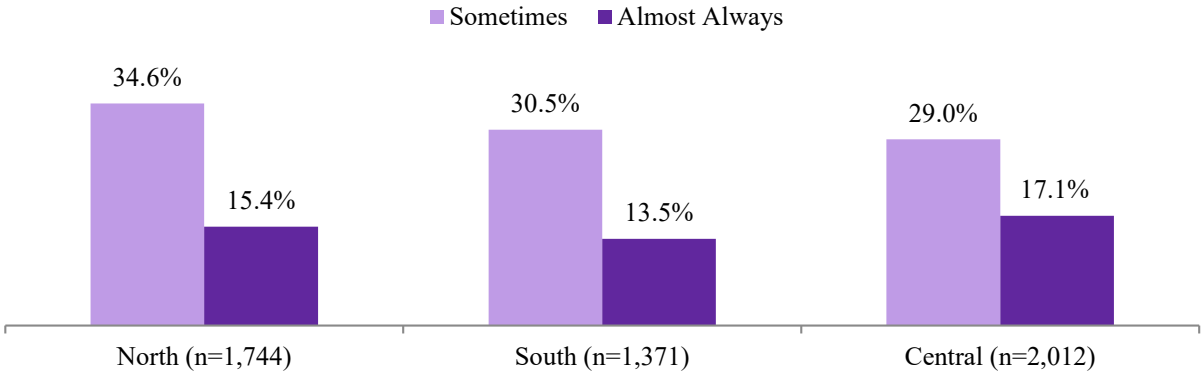
CalOptima language:



Age Category:

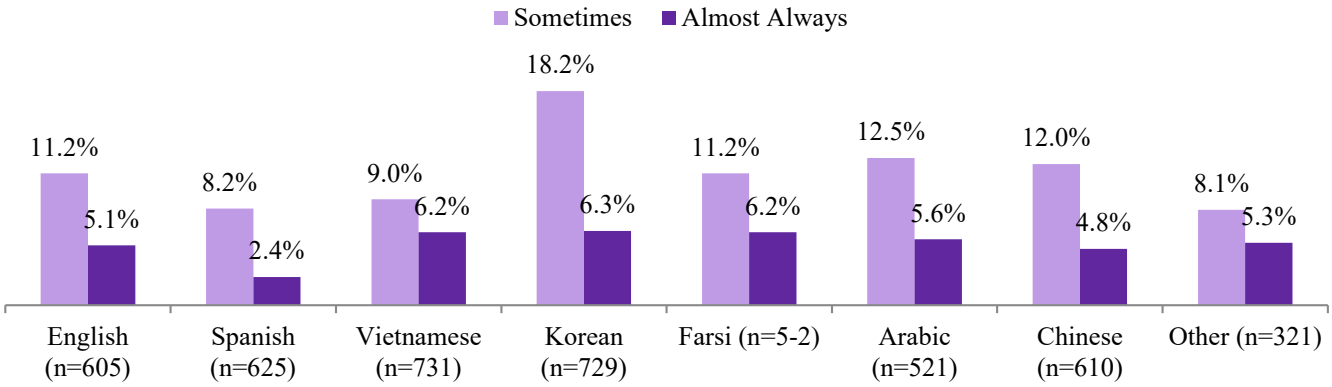


Region:

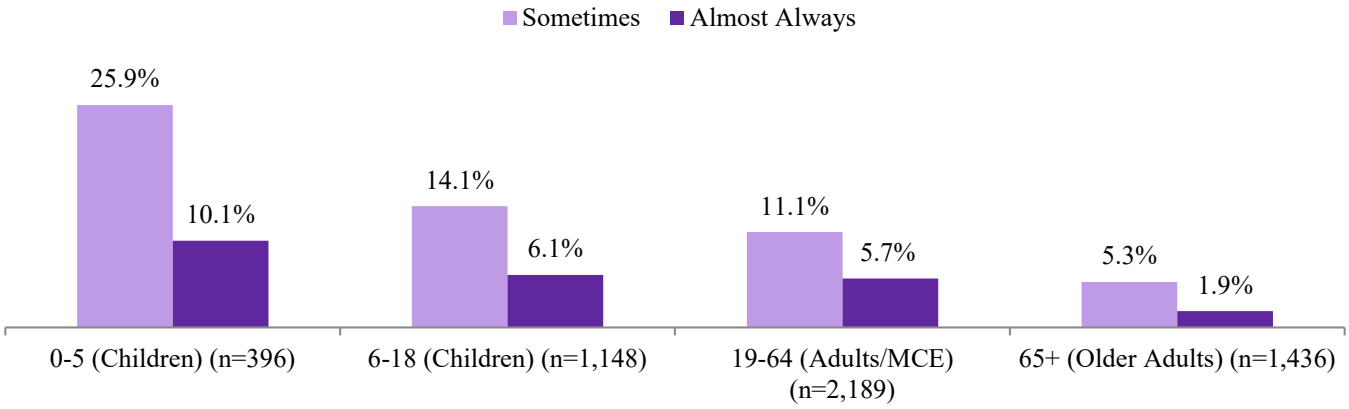


Child care:

CalOptima language:



Age Category:



Region:

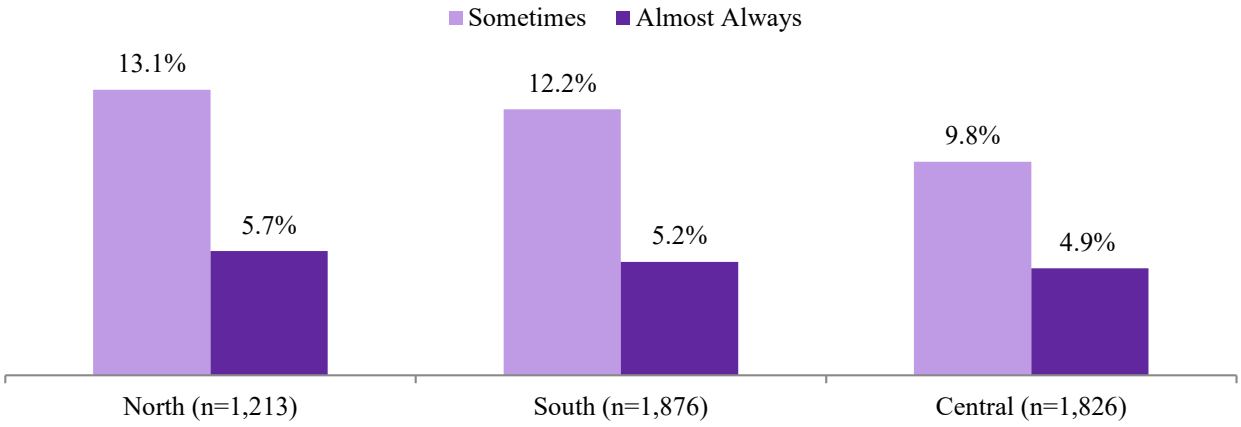
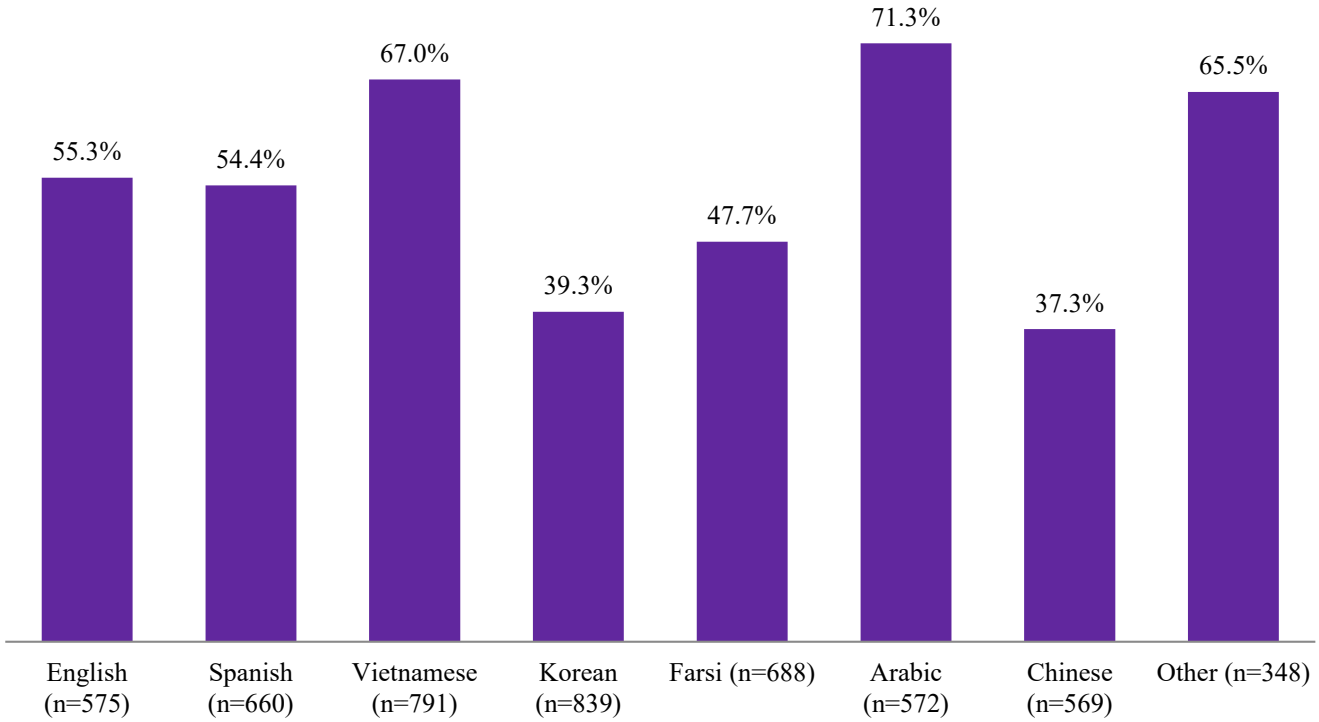


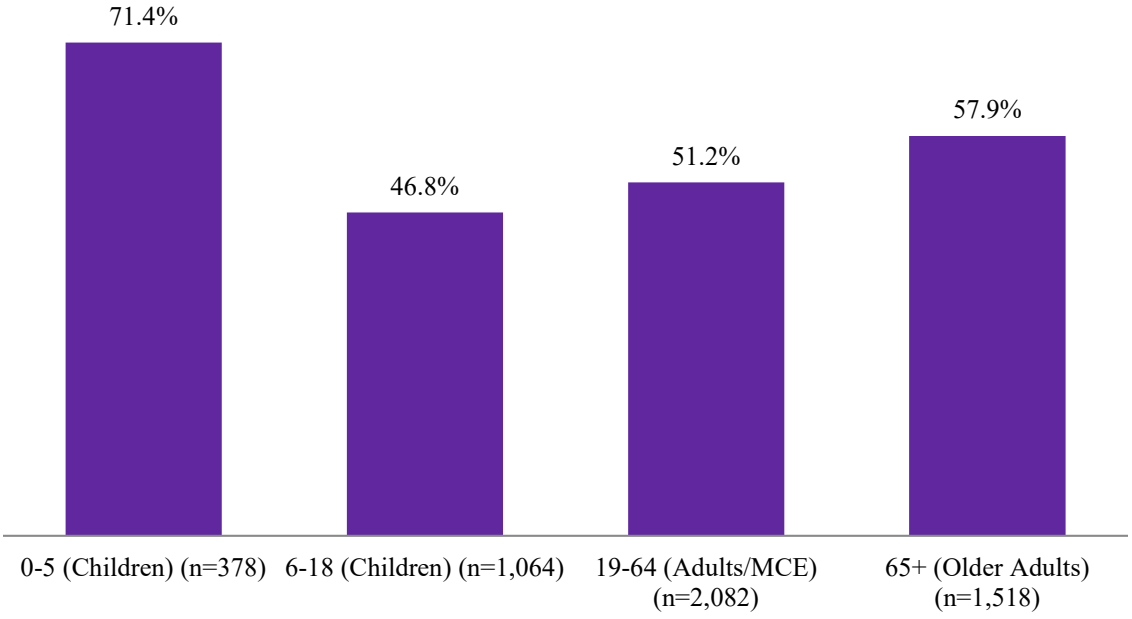
Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

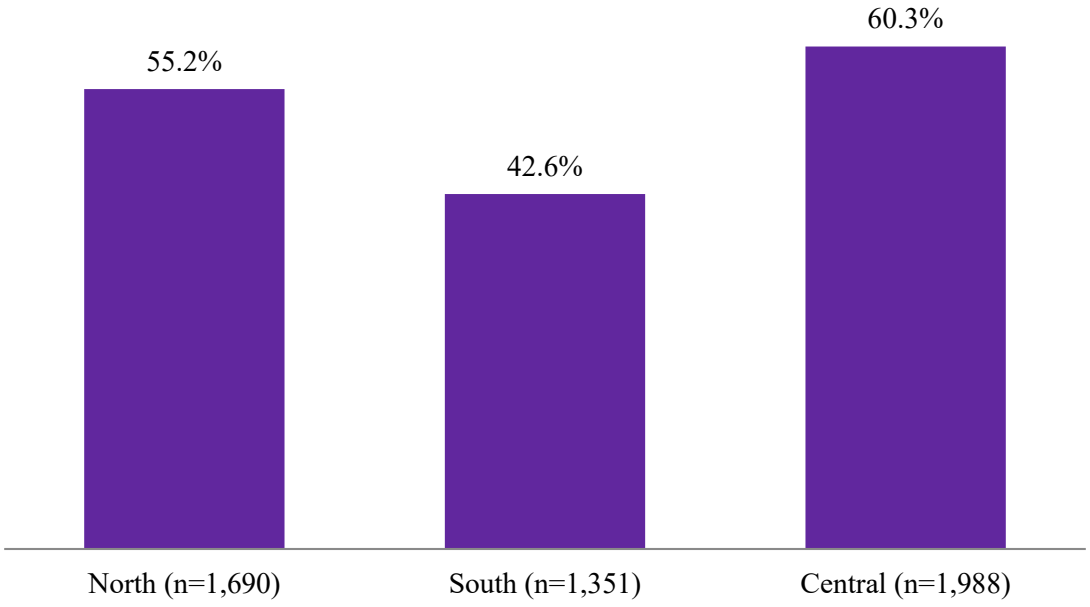
CalOptima language:



Age Category:



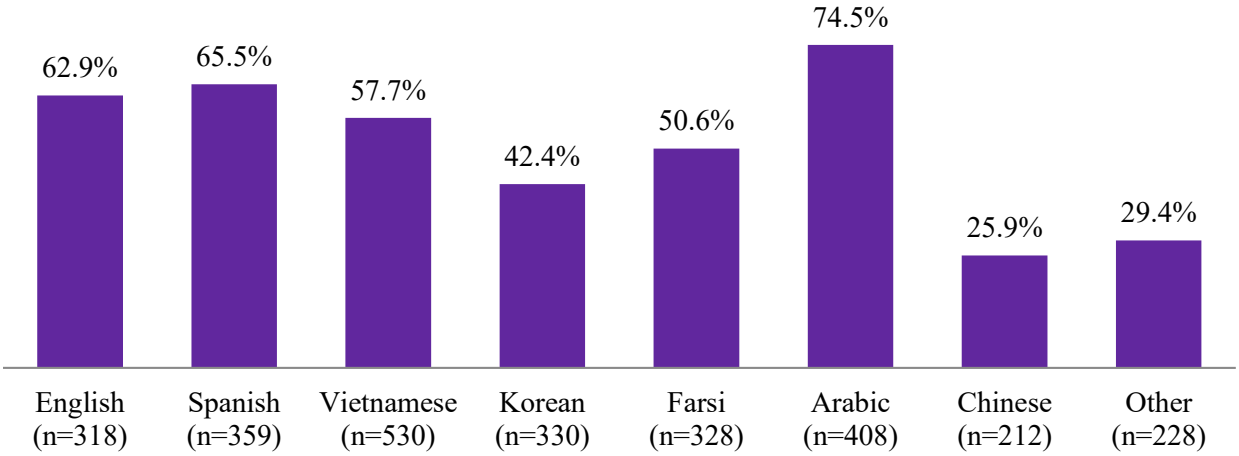
Region:



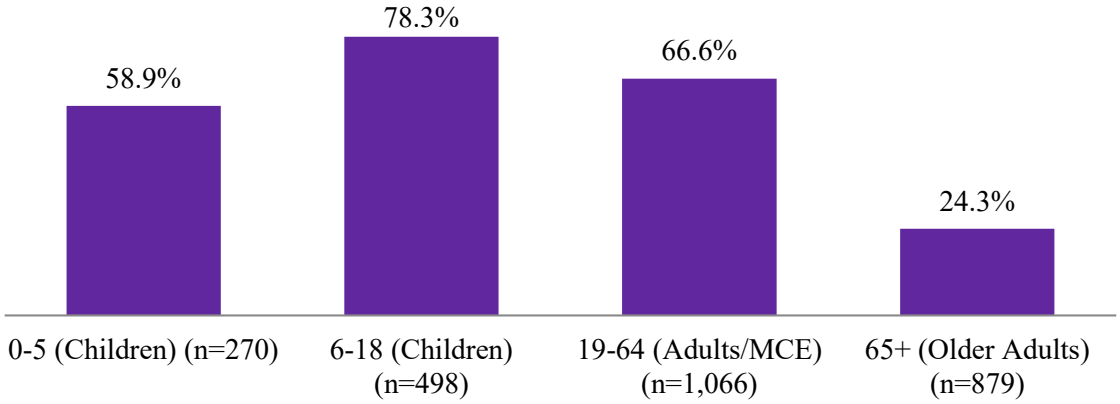
Type of public benefits that members receive[8]:

Receive CalFresh as a public benefit:

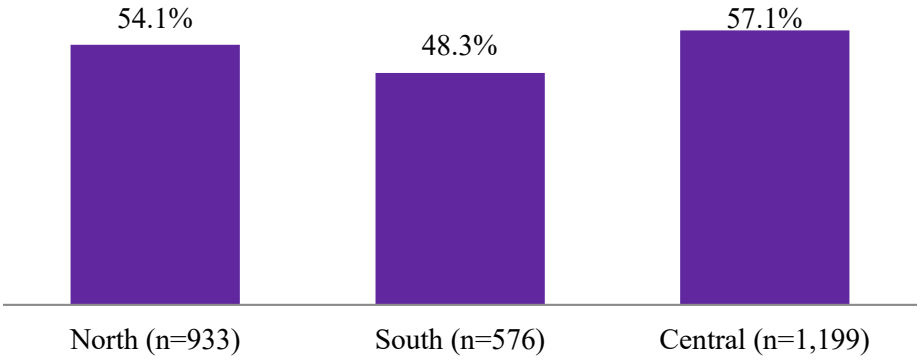
CalOptima language:



Age Category:



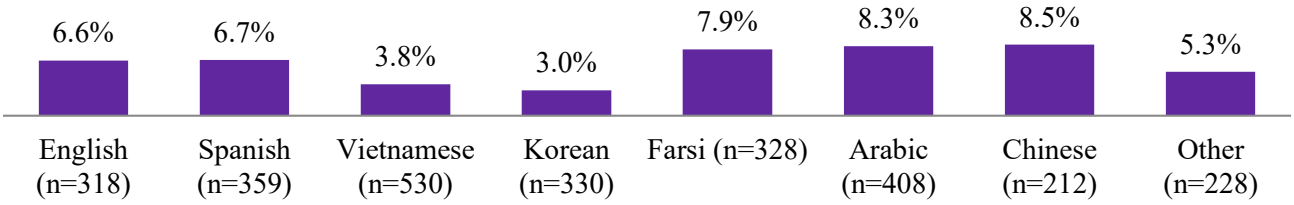
Region:



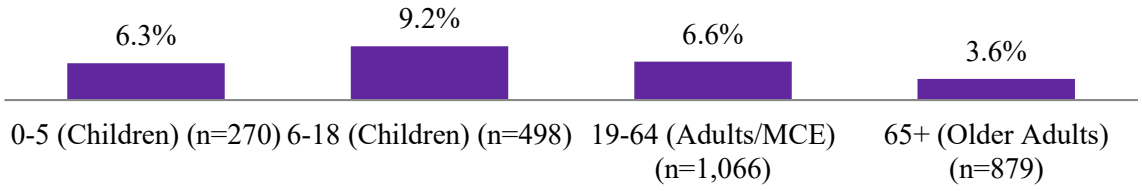
[8] Only reporting those who reported that they received at least one public benefit.

Receive TANF or CalWorks as a public benefit:

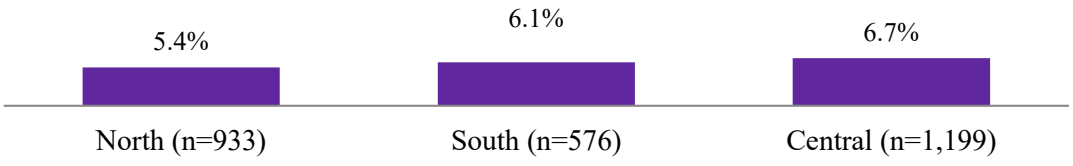
CalOptima language:



Age Category:

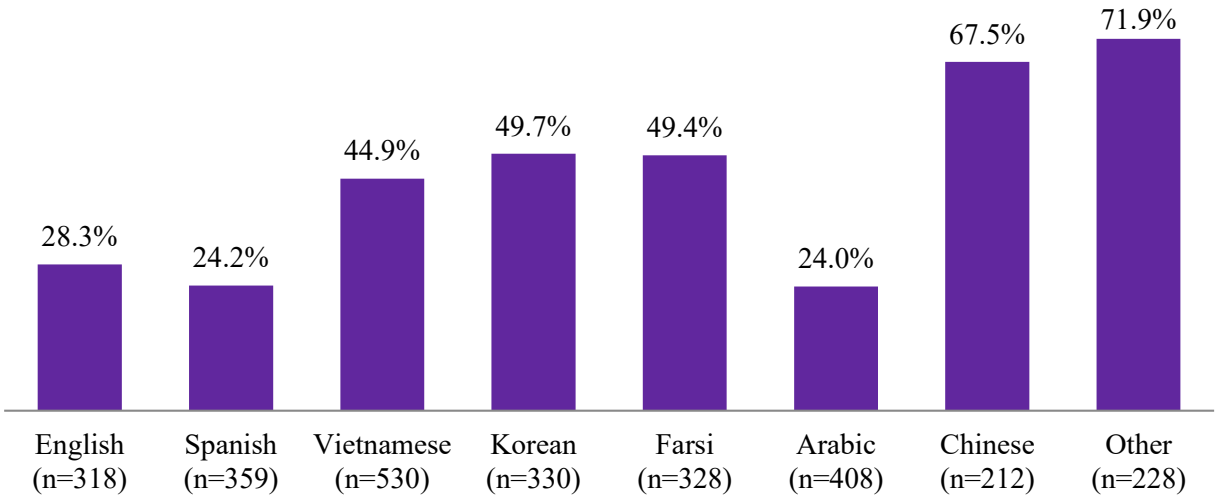


Region:

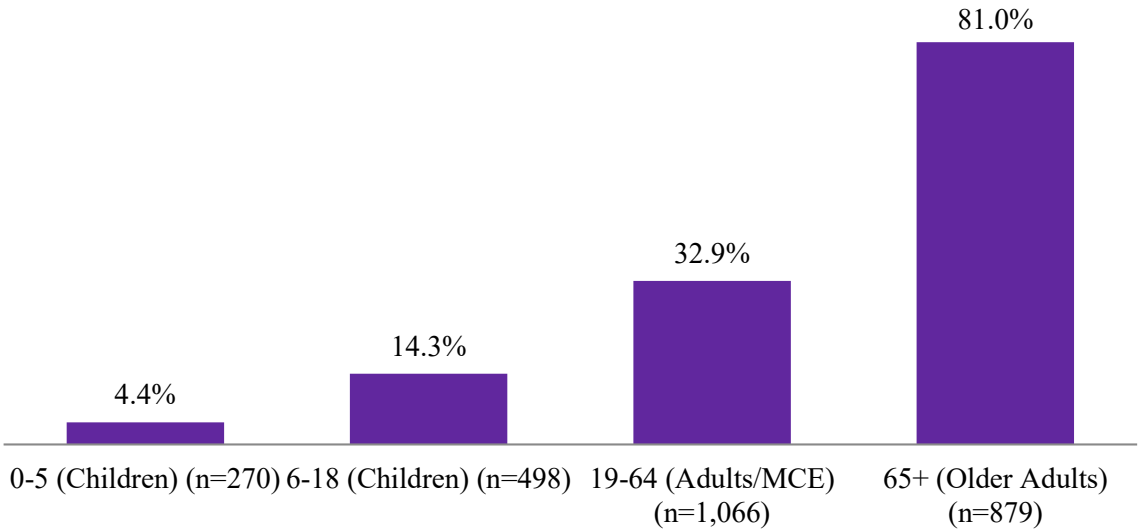


Receive SSI or SSDI as a public benefit:

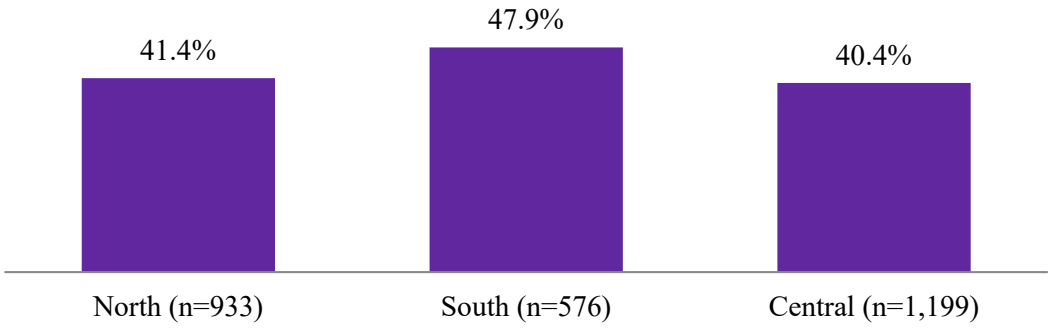
CalOptima language:



Age Category:

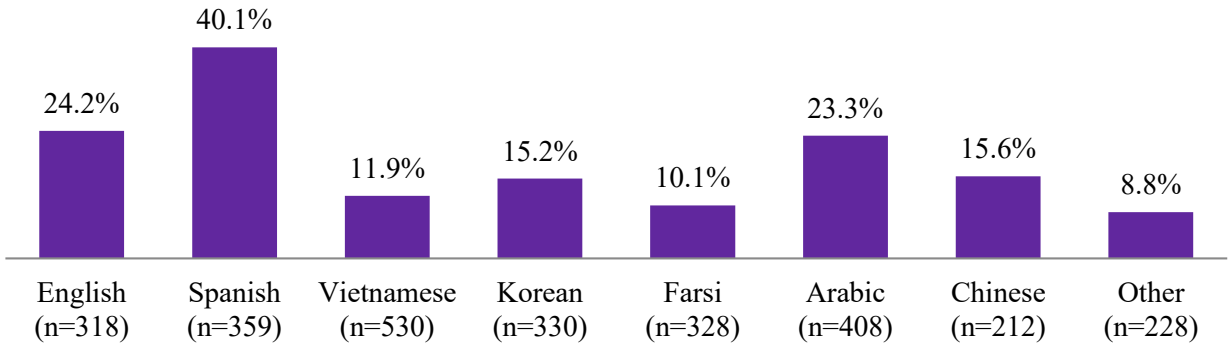


Region:

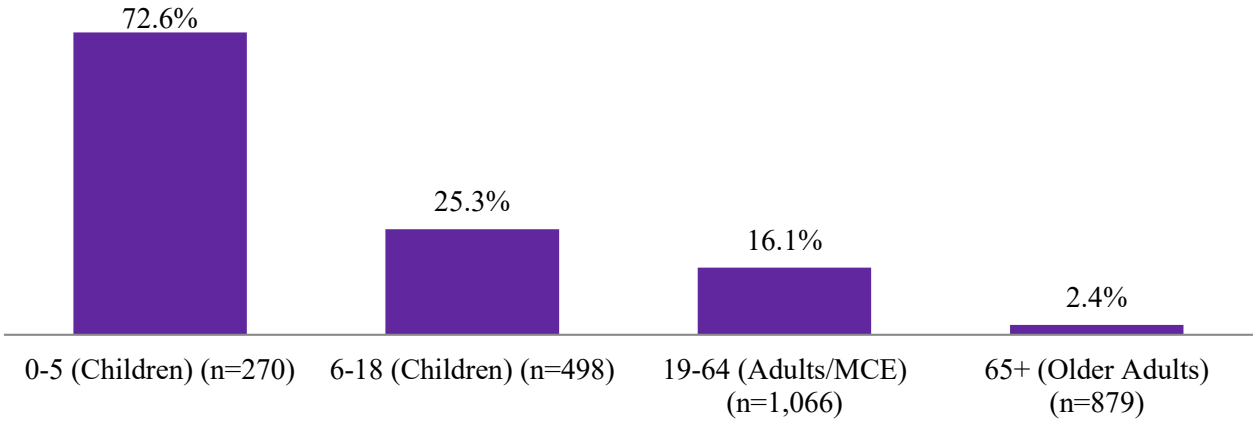


Receive WIC as a public benefit:

CalOptima language:



Age Category:



Region:

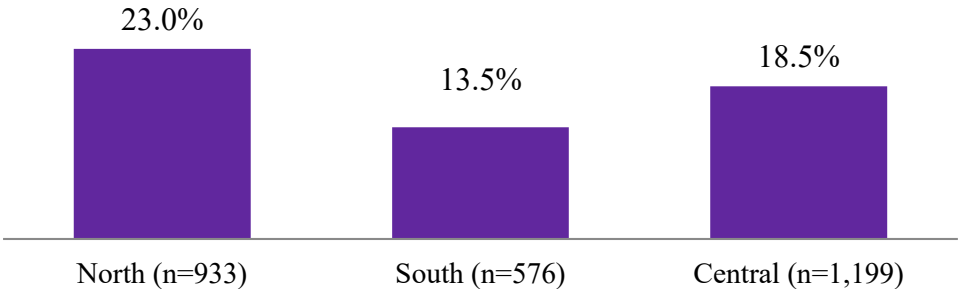


Exhibit 15. Personal activities participation:

CalOptima language:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	41.2%	6.4%	6.4%	45.9%	621
Spanish	19.1%	4.3%	3.1%	73.5%	607
Vietnamese	53.5%	3.3%	4.3%	38.9%	766
Korean	35.4%	6.3%	2.3%	56.0%	809
Farsi	28.5%	3.2%	3.4%	65.0%	537
Arabic	47.2%	5.9%	1.9%	45.0%	540
Chinese	16.8%	3.8%	3.1%	76.3%	583
Other	32.3%	4.0%	5.1%	58.6%	350
Do fun activities with others	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
English	63.3%	18.3%	7.4%	11.0%	635
Spanish	61.8%	13.0%	4.0%	21.2%	647
Vietnamese	49.6%	19.5%	9.3%	21.7%	789
Korean	51.9%	22.7%	7.3%	18.0%	859
Farsi	39.5%	25.0%	10.2%	**25.3%**	608
Arabic	54.8%	20.6%	6.7%	17.9%	586
Chinese	45.4%	12.1%	5.8%	**36.7%**	619
Other	46.3%	21.6%	11.6%	20.5%	361

Volunteer or charity	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	16.2%	15.8%	19.4%	48.6%	628
Spanish	15.9%	10.0%	9.9%	64.2%	628
Vietnamese	15.8%	19.1%	26.7%	38.3%	752
Korean	21.0%	13.2%	15.6%	50.2%	825
Farsi	15.4%	13.8%	19.9%	50.9%	578
Arabic	23.5%	18.1%	14.3%	44.2%	575
Chinese	16.5%	11.9%	14.0%	57.7%	607
Other	9.9%	7.0%	12.1%	71.0%	355

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	68.7%	11.5%	6.0%	13.7%	633
Spanish	66.0%	8.7%	2.8%	22.5%	644
Vietnamese	69.6%	6.6%	4.0%	19.8%	807
Korean	75.1%	10.1%	3.7%	11.2%	874
Farsi	68.9%	7.7%	5.6%	17.9%	627
Arabic	59.1%	11.8%	4.4%	24.7%	587
Chinese	71.9%	7.3%	3.8%	17.1%	661
Other	57.6%	10.2%	4.7%	27.5%	363

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	83.3%	6.0%	1.0%	9.6%	612
Spanish	85.1%	5.3%	1.0%	8.6%	590
Vietnamese	78.0%	5.1%	1.5%	15.4%	740
Korean	88.2%	6.3%	1.0%	4.5%	842
Farsi	84.3%	4.8%	1.9%	8.9%	516
Arabic	83.2%	5.5%	1.5%	9.8%	531
Chinese	86.9%	5.2%	1.1%	6.7%	610
Other	80.3%	6.7%	3.5%	9.5%	315

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	76.7%	12.2%	2.9%	8.2%	621
Spanish	80.1%	7.7%	2.9%	9.3%	613
Vietnamese	78.2%	7.7%	1.9%	12.1%	725
Korean	73.6%	13.8%	4.6%	8.0%	864
Farsi	78.4%	9.9%	3.7%	8.0%	538
Arabic	74.5%	11.4%	2.7%	11.4%	553
Chinese	85.9%	5.3%	2.4%	6.3%	618
Other	82.9%	9.2%	3.5%	4.4%	315

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	0.8%	1.1%	6.2%	91.9%	632
Spanish	0.2%	0.3%	2.5%	97.1%	651
Vietnamese	2.6%	0.6%	3.1%	93.7%	772
Korean	0.8%	0.8%	6.5%	91.8%	846
Farsi	1.3%	1.0%	2.9%	94.8%	594
Arabic	5.0%	2.4%	1.0%	91.6%	582
Chinese	7.5%	2.3%	3.3%	86.8%	598
Other	2.2%	2.0%	8.1%	87.7%	358

Age Category:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	32.2%	3.4%	2.0%	62.4%	348
6-18 (Children)	33.0%	3.9%	2.5%	60.6%	1,077
19-64 (Adults/MCE)	43.2%	5.6%	4.2%	47.0%	2,093
65+ (Older Adults)	24.3%	4.3%	4.2%	67.2%	1,295

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	75.0%	9.8%	2.9%	12.2%	376
6-18 (Children)	72.5%	12.3%	4.7%	10.6%	1,137
19-64 (Adults/MCE)	43.6%	24.2%	9.3%	23.0%	2,190
65+ (Older Adults)	41.9%	19.2%	8.6%	30.3%	1,401

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	14.5%	10.4%	11.0%	64.1%	365
6-18 (Children)	22.7%	18.3%	17.2%	41.8%	1,117
19-64 (Adults/MCE)	18.0%	14.9%	20.8%	46.3%	2,142
65+ (Older Adults)	12.1%	10.1%	12.2%	65.6%	1,324

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	69.2%	7.0%	1.9%	21.9%	370
6-18 (Children)	77.9%	8.4%	3.2%	10.5%	1,148
19-64 (Adults/MCE)	62.2%	12.6%	5.7%	19.5%	2,211
65+ (Older Adults)	69.3%	4.9%	3.6%	22.2%	1,467

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	89.8%	3.6%	0.6%	6.1%	362
6-18 (Children)	90.2%	4.5%	0.9%	4.3%	1,084
19-64 (Adults/MCE)	80.5%	6.7%	1.7%	11.0%	2,061
65+ (Older Adults)	82.4%	5.2%	1.6%	10.8%	1,249

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	79.0%	6.4%	3.6%	11.0%	362
6-18 (Children)	83.2%	7.7%	2.4%	6.7%	1,110
19-64 (Adults/MCE)	70.7%	14.3%	4.3%	10.8%	2,105
65+ (Older Adults)	86.5%	5.3%	1.7%	6.5%	1,270

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	3.0%	0.5%	1.6%	94.8%	368
6-18 (Children)	2.3%	0.6%	1.8%	95.3%	1,134
19-64 (Adults/MCE)	1.9%	1.0%	5.4%	91.7%	2,171
65+ (Older Adults)	3.2%	2.3%	4.6%	89.9%	1,360

Region:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	35.3%	5.4%	3.7%	55.6%	1,639
South	28.8%	4.2%	4.0%	62.9%	1,252
Central	38.8%	4.4%	3.4%	53.4%	1,910

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	51.8%	20.1%	8.0%	20.0%	1,757
South	47.7%	21.1%	8.0%	23.2%	1,345
Central	55.0%	16.6%	6.9%	21.5%	1,989

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	17.7%	13.8%	16.0%	52.5%	1,702
South	16.8%	13.2%	16.8%	53.3%	1,307
Central	17.1%	14.9%	17.9%	50.1%	1,927

Physical fitness	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	67.4%	10.2%	4.9%	17.5%	1,780
South	69.4%	8.8%	4.4%	17.4%	1,387
Central	67.9%	8.3%	3.7%	20.1%	2,017

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	86.8%	4.7%	0.8%	7.7%	1,668
South	86.0%	5.3%	1.8%	6.9%	1,230
Central	79.9%	6.6%	1.7%	11.8%	1,848

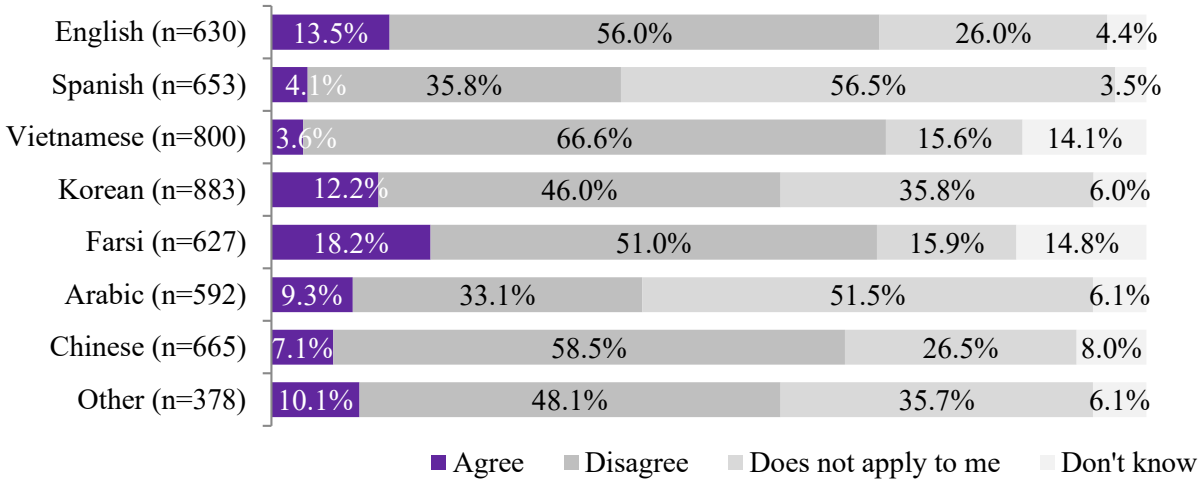
Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	76.2%	10.9%	3.8%	9.1%	1,694
South	81.0%	9.2%	3.3%	6.5%	1,263
Central	78.5%	9.2%	2.3%	9.9%	1,880

Visit a casino or gamble on the internet	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	1.5%	0.9%	4.5%	93.2%	1,726
South	4.0%	1.1%	3.7%	91.3%	1,327
Central	2.2%	1.7%	4.0%	92.1%	1,969

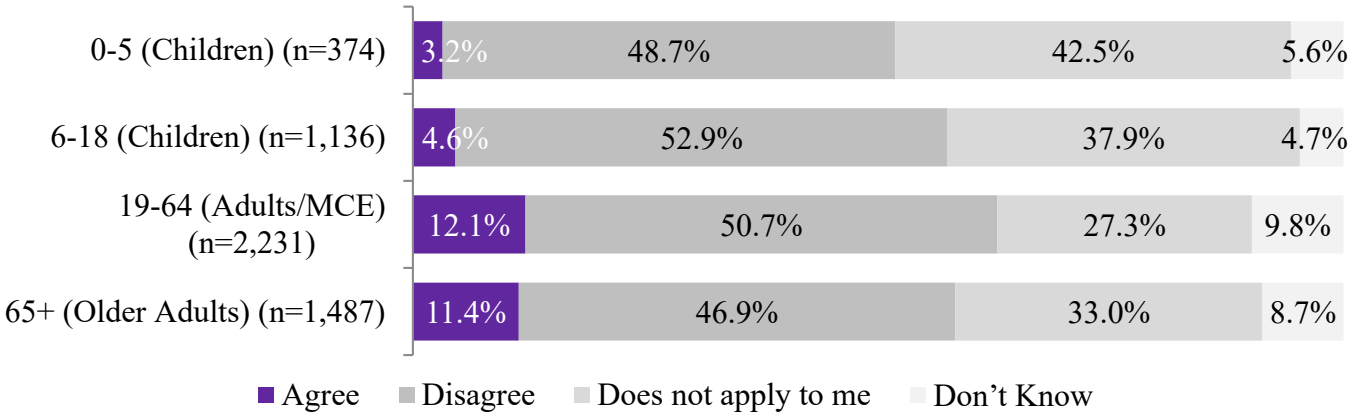
Exhibit 16. Feelings towards community and home enviroment:

Feeling lonely and isolated:

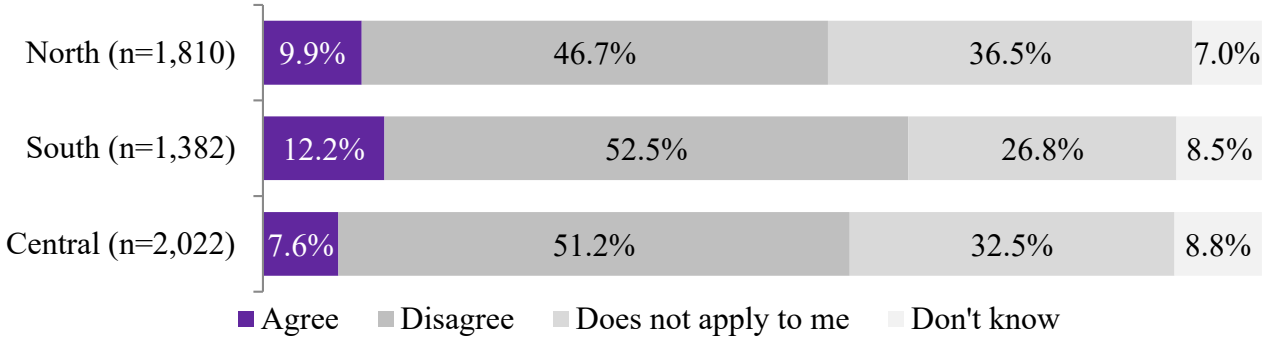
CalOptima language:



Age Category:

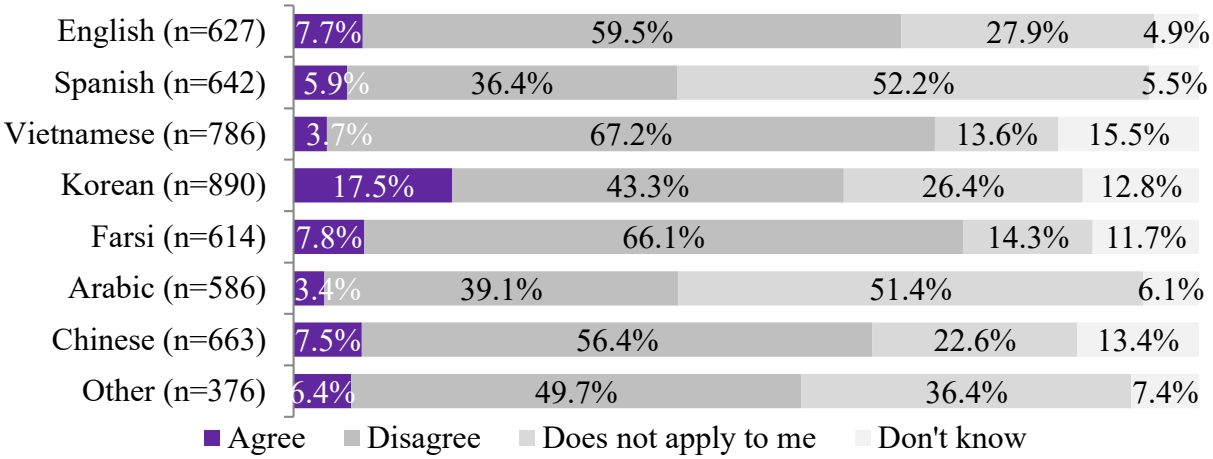


Region:

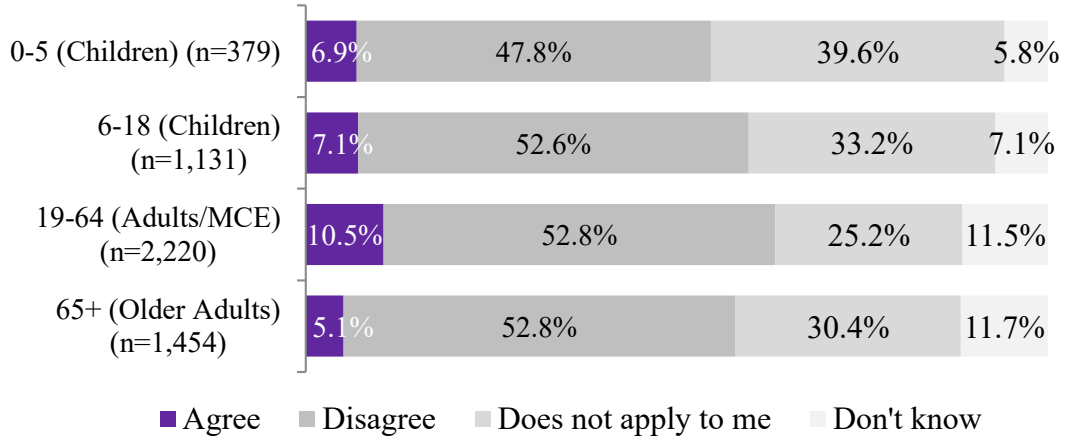


Feel not treated equally because of ethnic and culutral backgrounds:

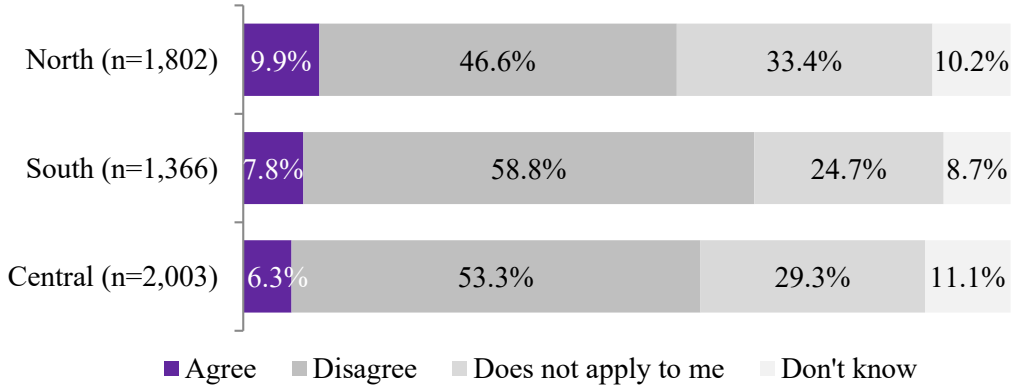
CalOptima language:



Age Category:

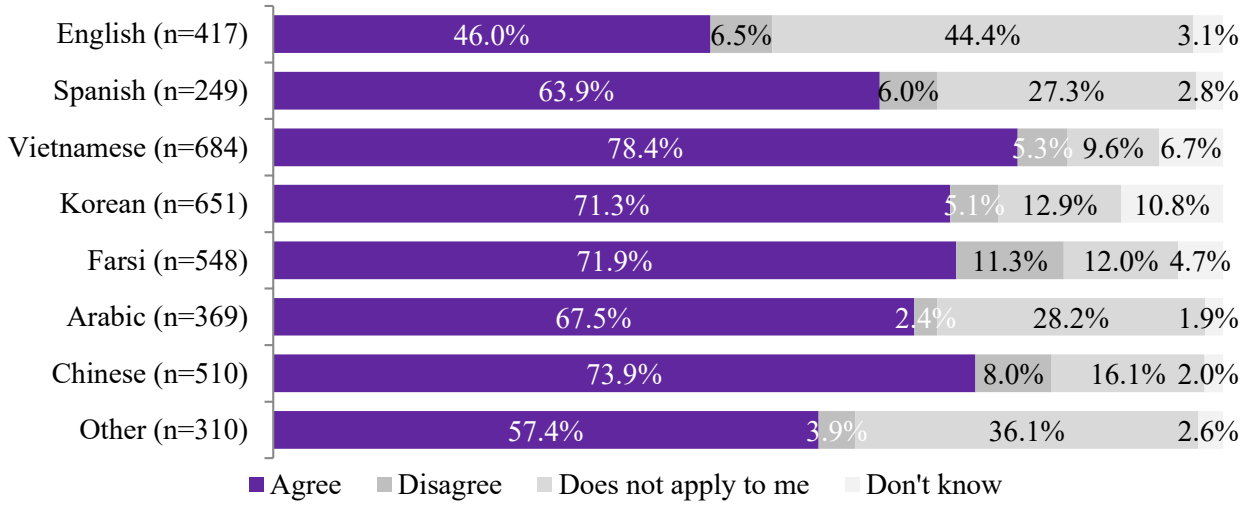


Region:



Feel child respects them as a parent[9]:

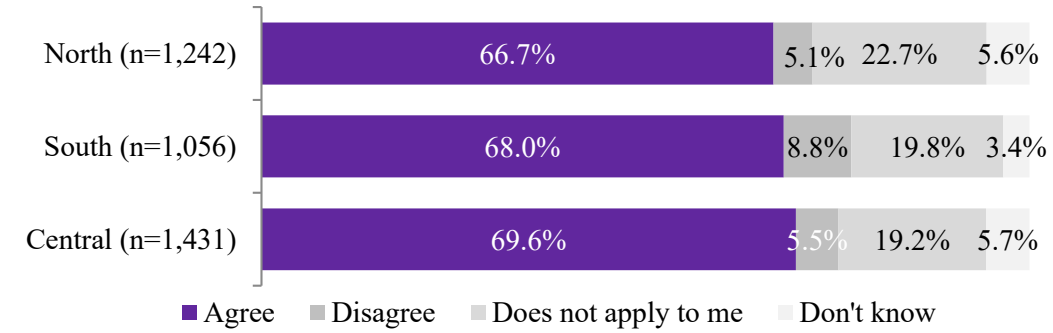
CalOptima language:



Age Category:



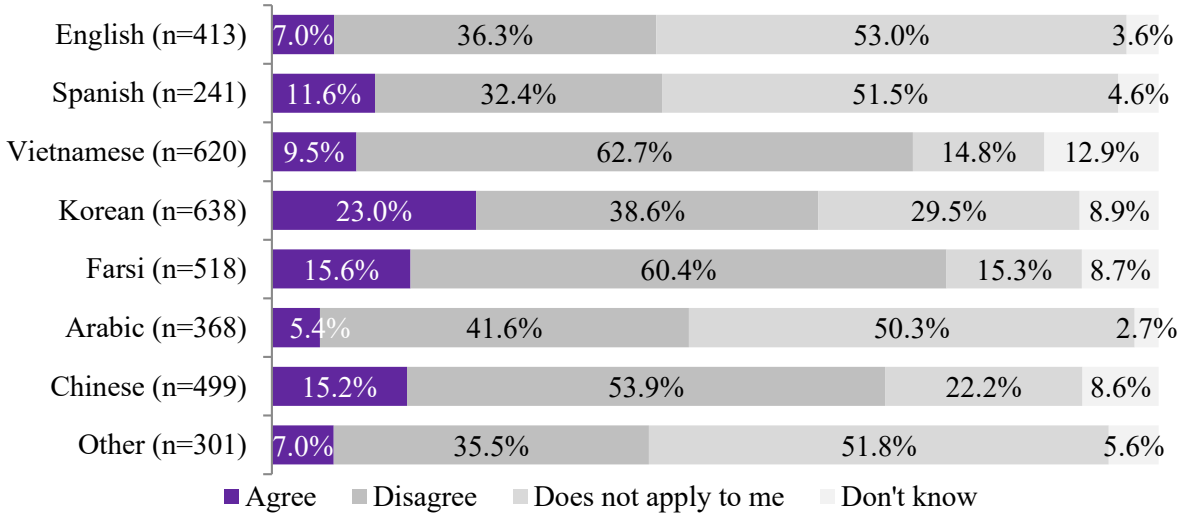
Region:



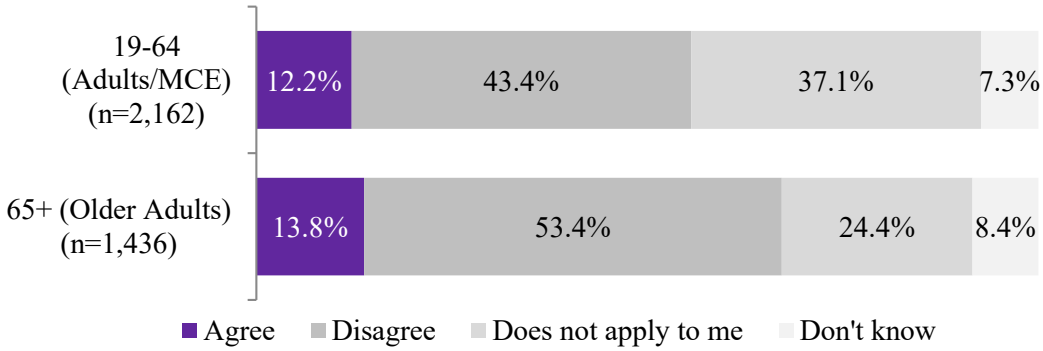
[9] Only reported those who are over 18 years old.

Feel child's attitudes and behavior conflict with cultural values[10]:

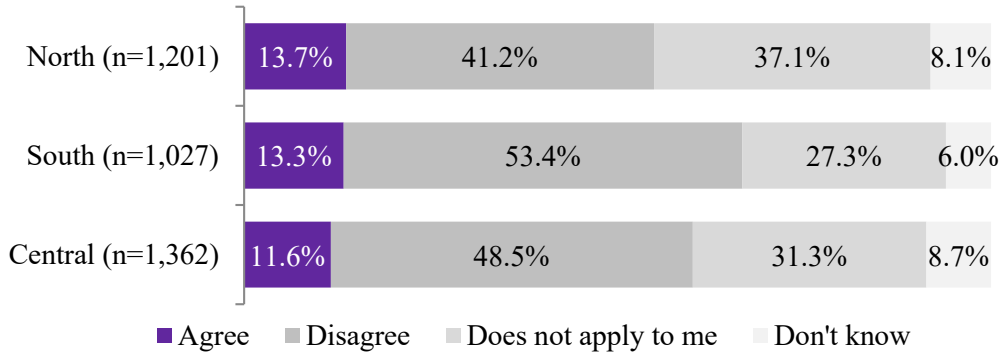
CalOptima language:



Age Category:



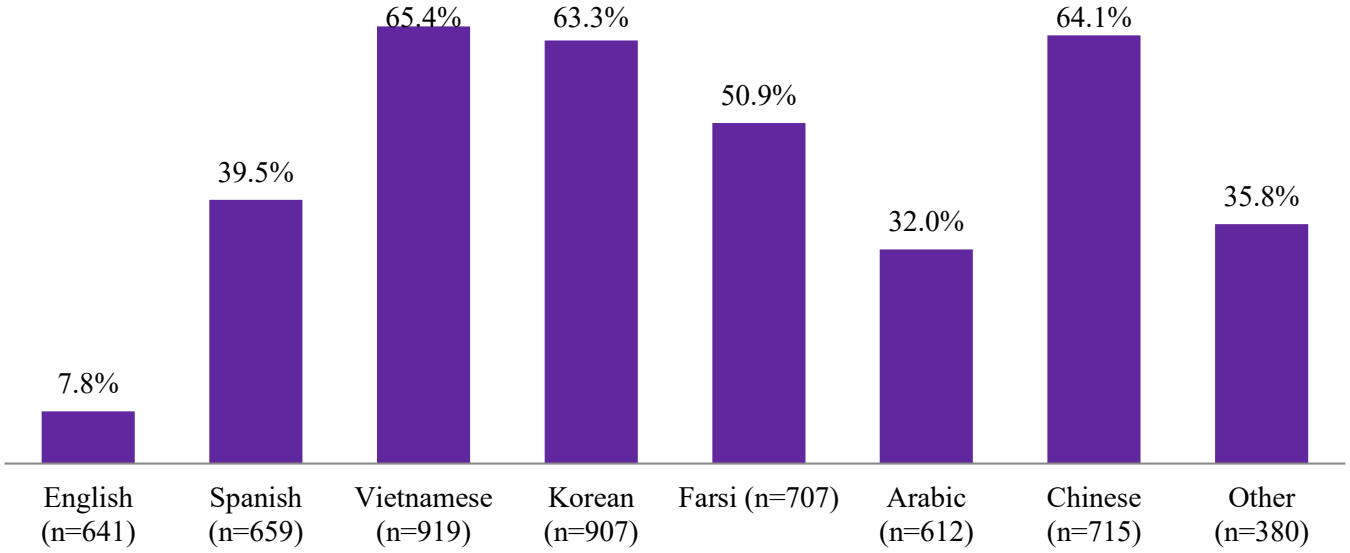
Region:



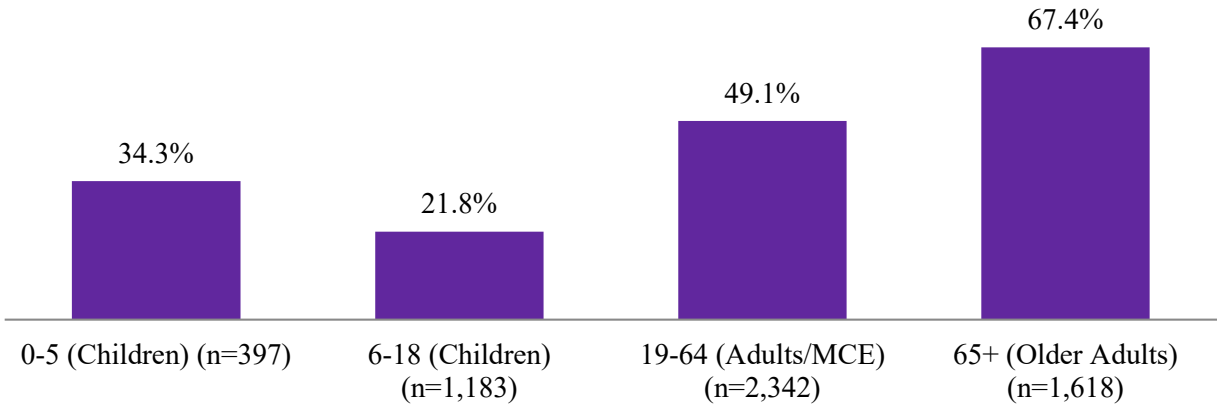
[10] Only reported those who are over 18 years old.

Exhibit 17. Members who reported that they speak English "not well":

CalOptima language:



Age Category:



Region:

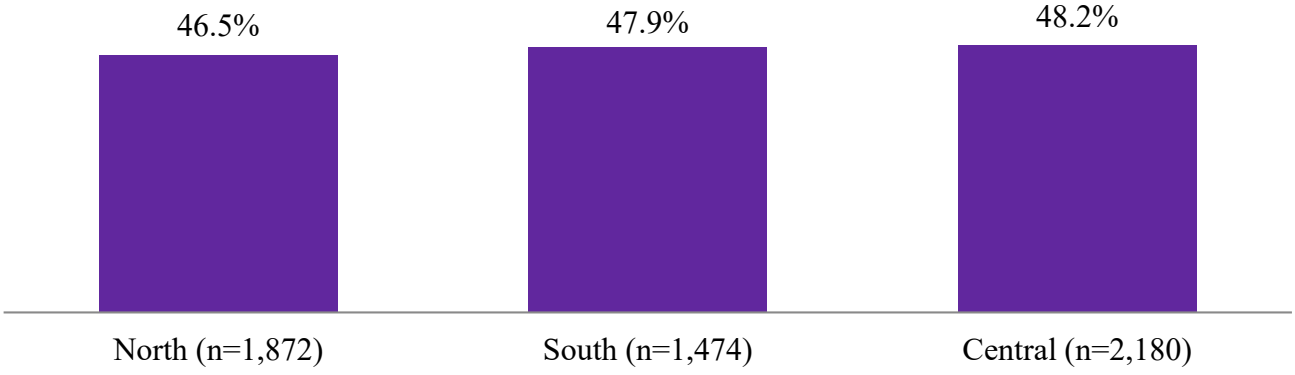


Exhibit 18. Employment status[11,12]

CalOptima language:

CalOptima language	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
English	36.7%	9.8%	7.2%	9.4%	13.4%	15.8%	20.4%	417
Spanish	21.7%	7.8%	11.6%	4.7%	21.3%	17.1%	28.3%	258
Vietnamese	32.1%	1.8%	12.1%	6.6%	24.4%	17.0%	20.0%	761
Korean	18.2%	11.6%	21.3%	6.9%	24.5%	10.0%	16.5%	638
Farsi	18.0%	4.4%	15.3%	7.6%	19.5%	26.5%	29.9%	616
Arabic	25.5%	4.2%	21.1%	9.4%	15.7%	11.9%	22.0%	427
Chinese	14.0%	3.8%	14.2%	4.9%	45.0%	6.8%	19.5%	529
Other	15.7%	3.4%	8.9%	3.7%	37.5%	10.2%	30.8%	325

Age Category:

Age Category	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
19-64 (Adults/MCE)	35.8%	8.3%	17.5%	10.9%	5.9%	17.6%	15.3%	2,370
65+ (Older Adults)	4.1%	1.7%	10.1%	0.7%	53.7%	10.5%	33.3%	1,601

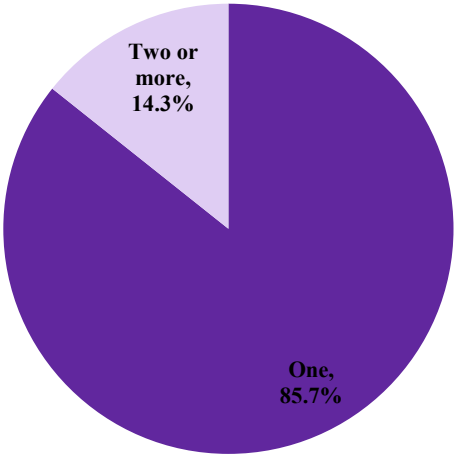
Region:

Region	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
North	24.0%	6.7%	15.9%	6.7%	23.6%	12.7%	22.5%	1,269
South	17.3%	6.6%	16.7%	7.3%	26.6%	17.3%	22.1%	1,129
Central	26.1%	4.0%	11.7%	6.5%	25.6%	14.7%	23.2%	1,561

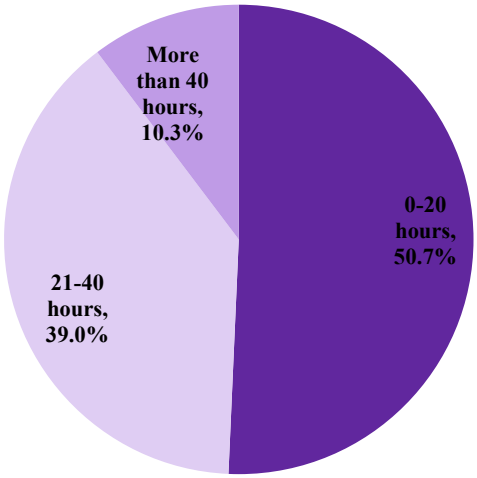
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]

Number of jobs members have

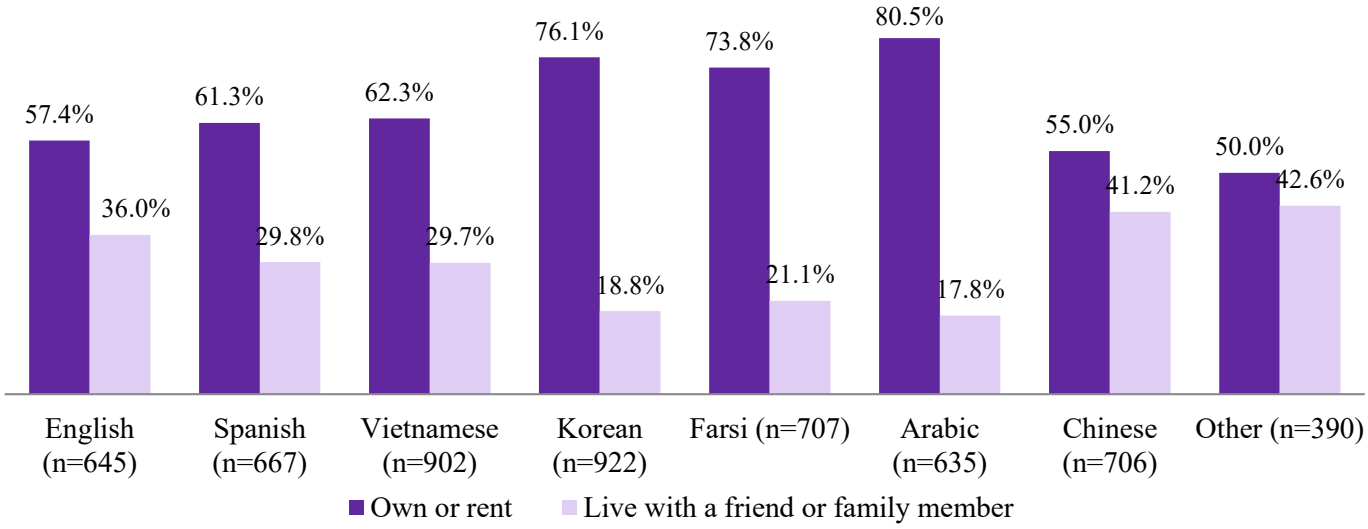


Number of hours that members work each week

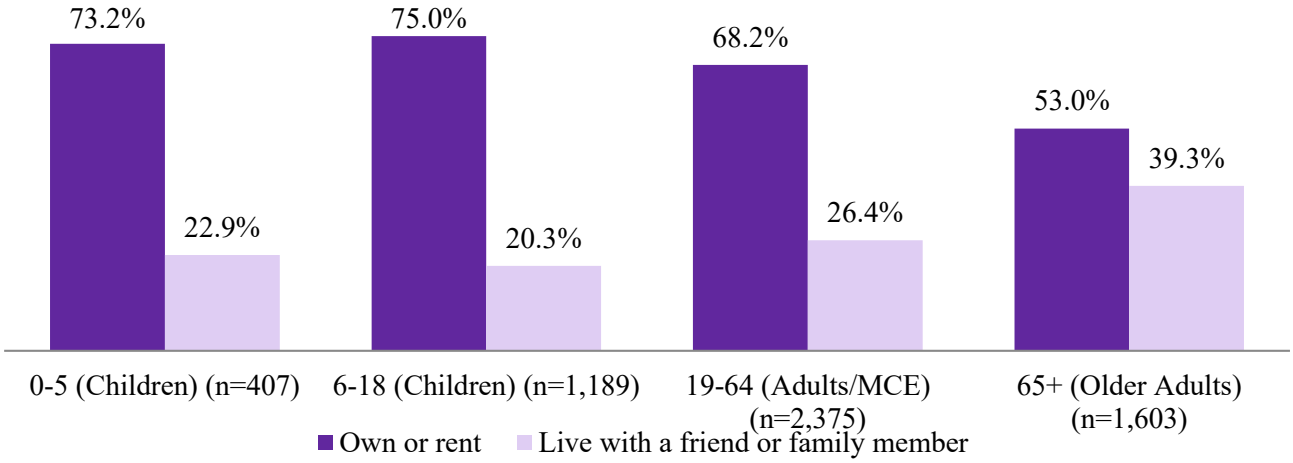


[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

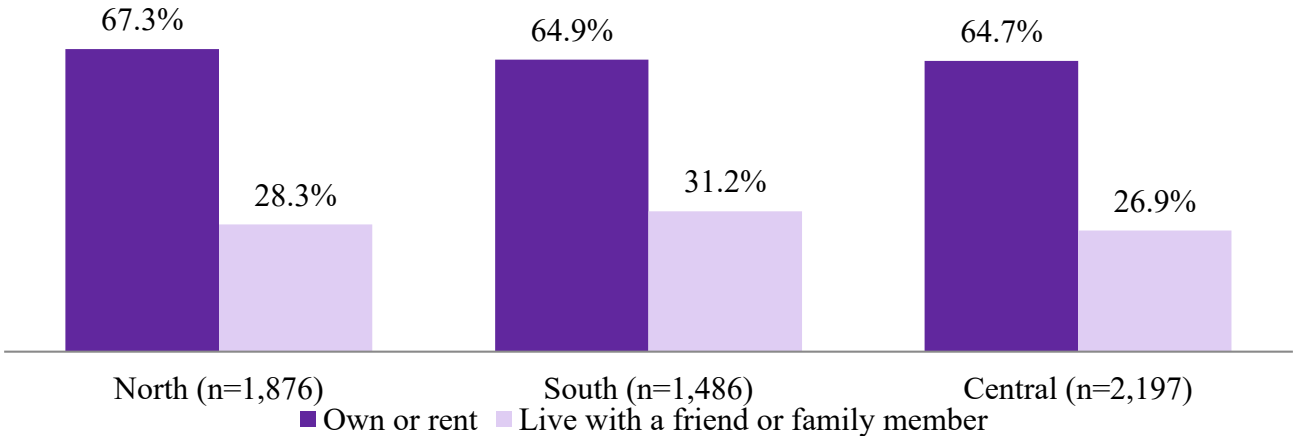
Exhibit 20. Members' living situation[14]



Age Category:



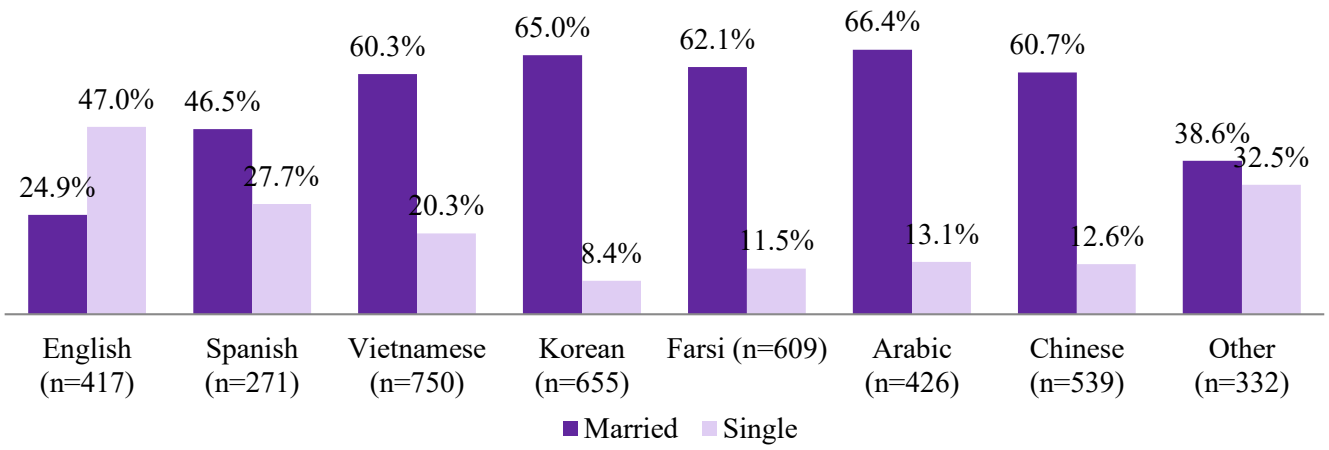
Region:



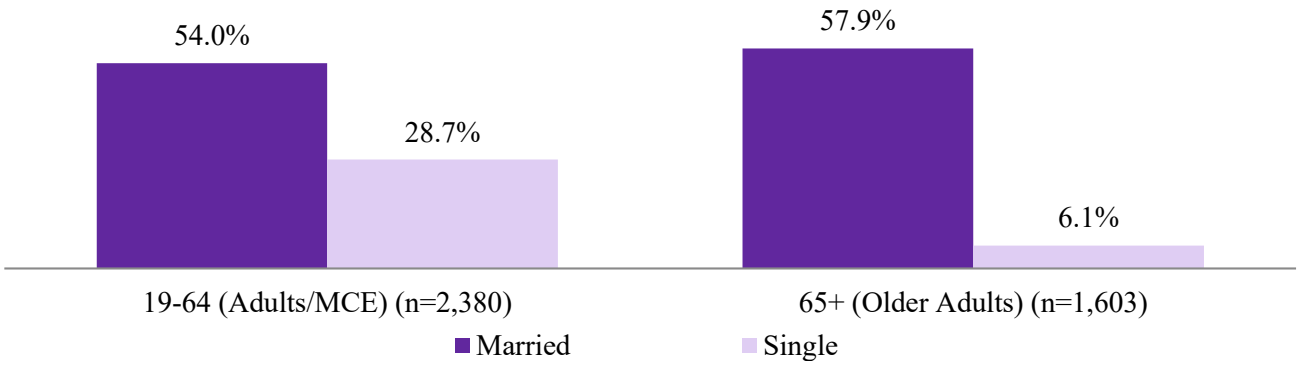
[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

Exhibit 21. Marital status of members[15],[16]

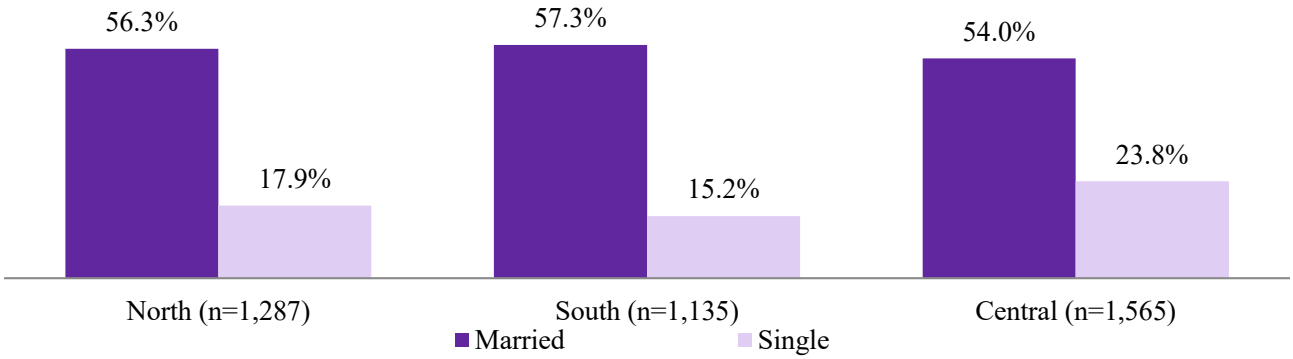
CalOptima language:



Age Category:



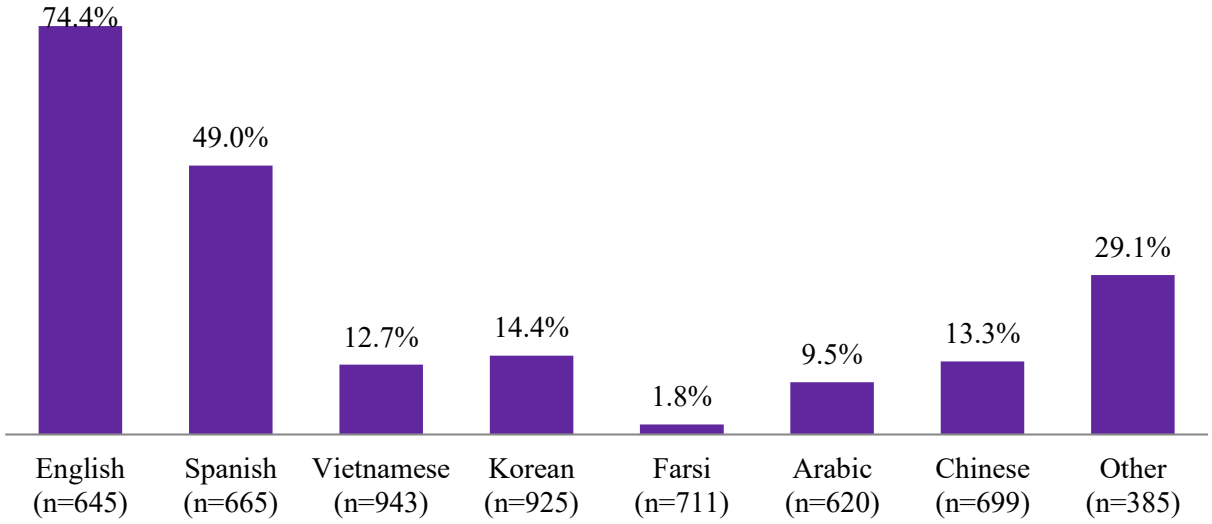
Region:



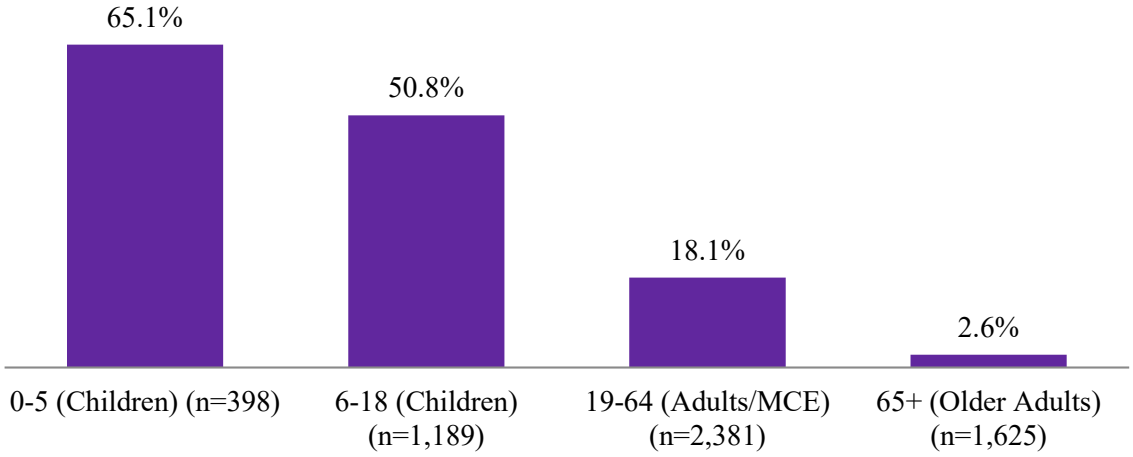
[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

Exhibit 22. Percent of members who were born in the United States:

CalOptima language:



Age Category:



Region:

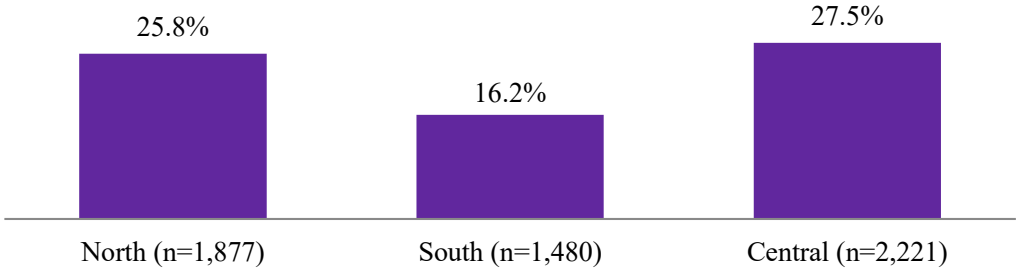
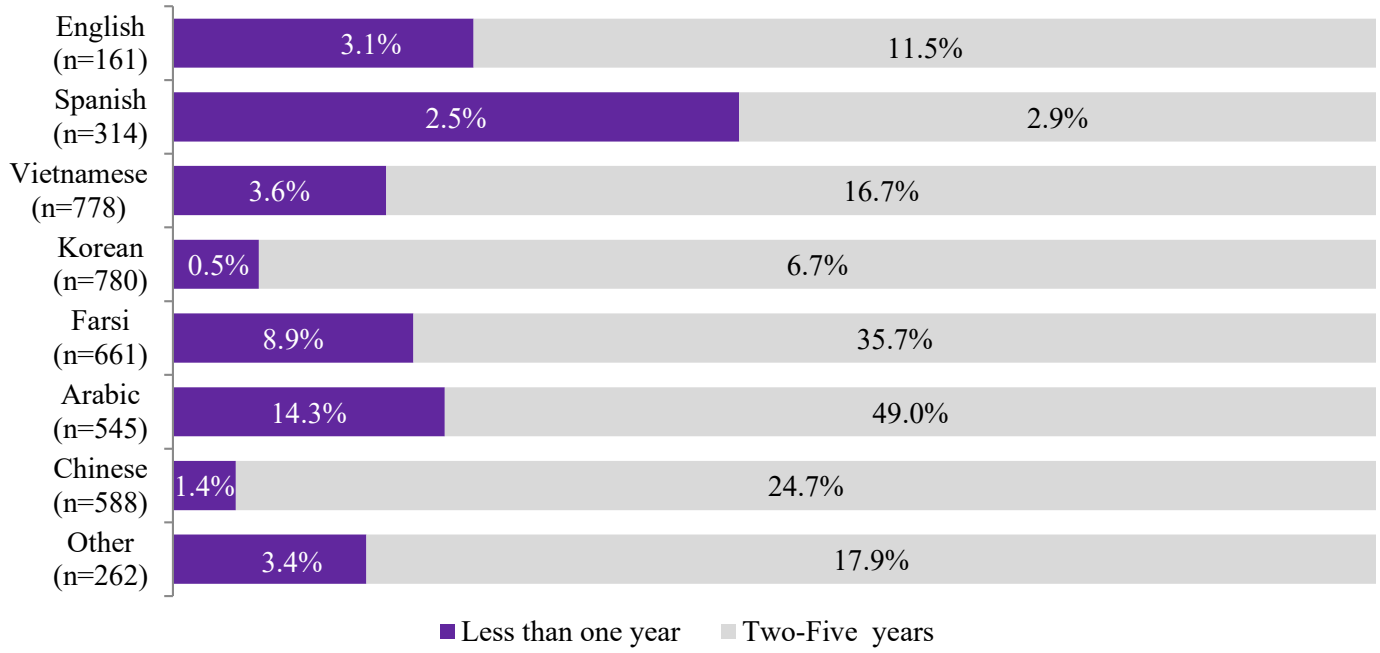
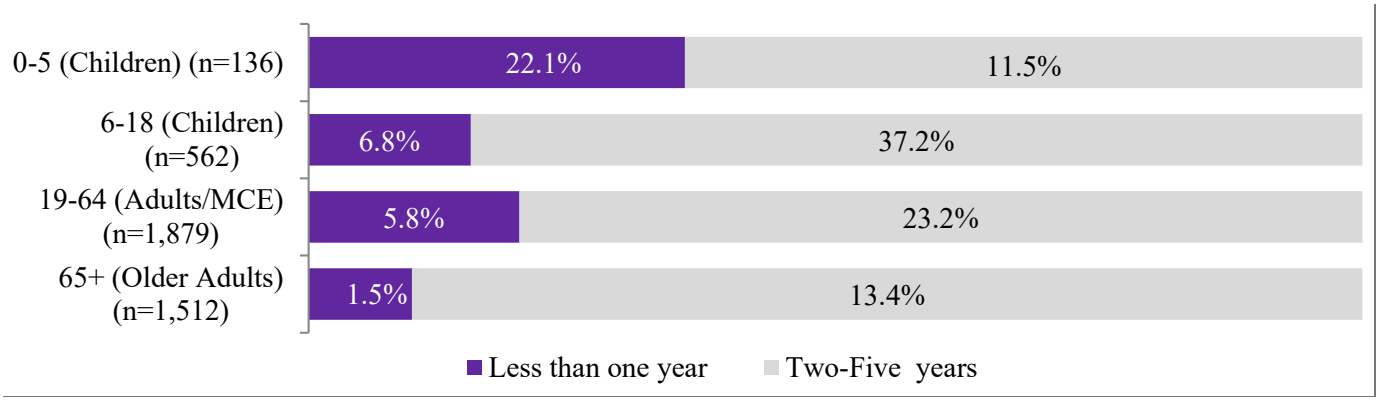


Exhibit 23. Length of time lived in the United States of those not born in the United States

CalOptima language:



Age Category:



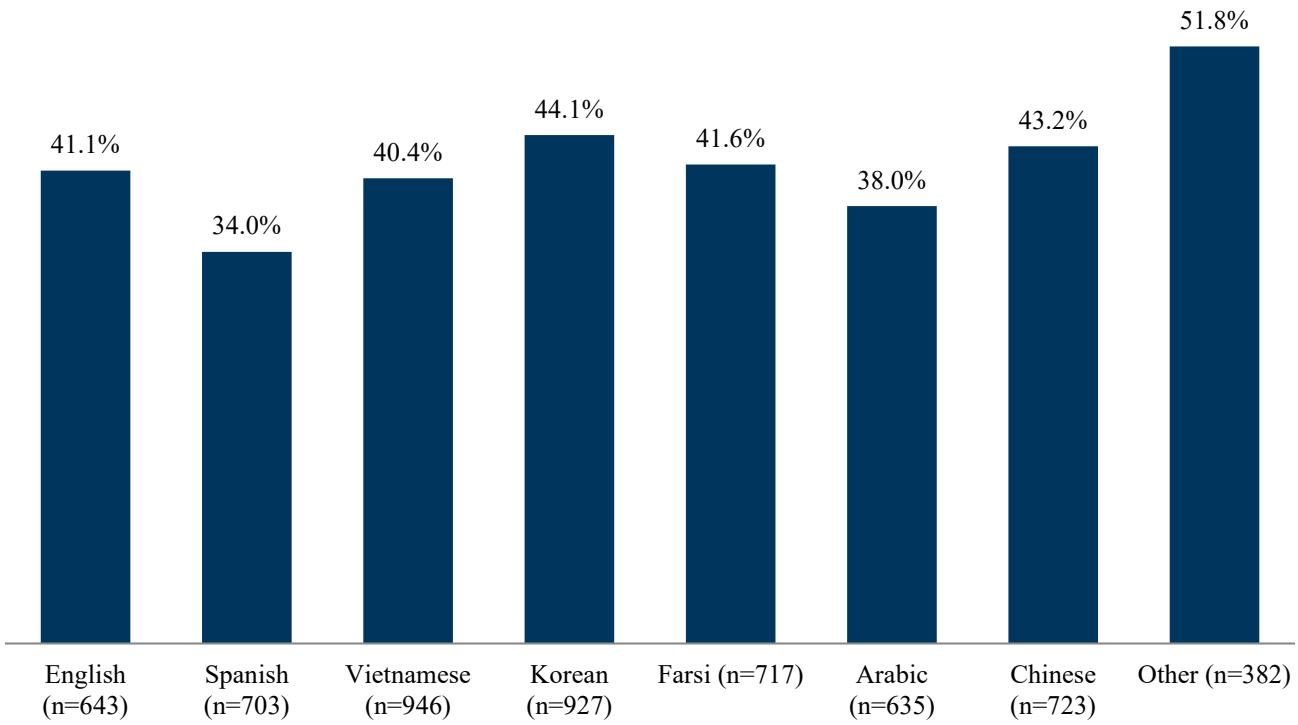
Region:



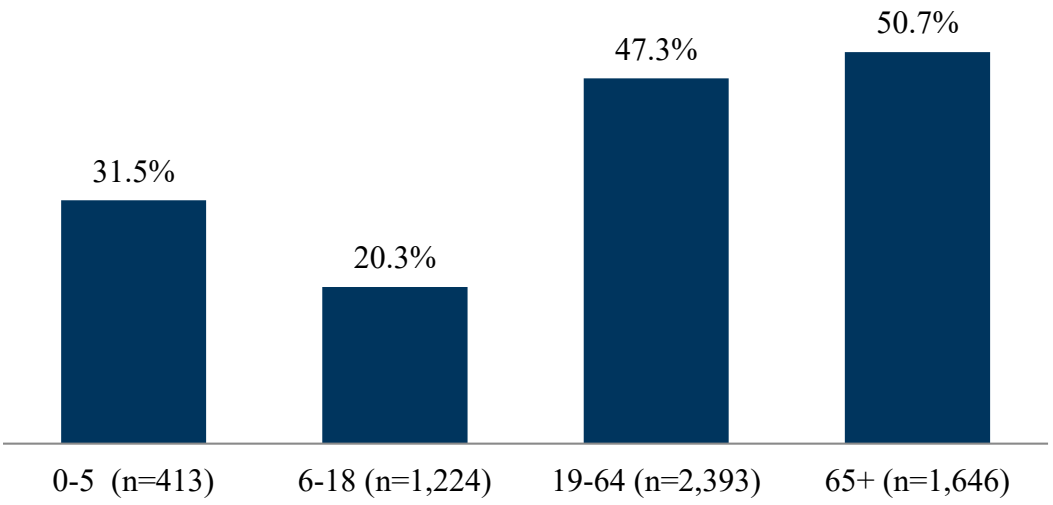
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:



Age Category:



Region:

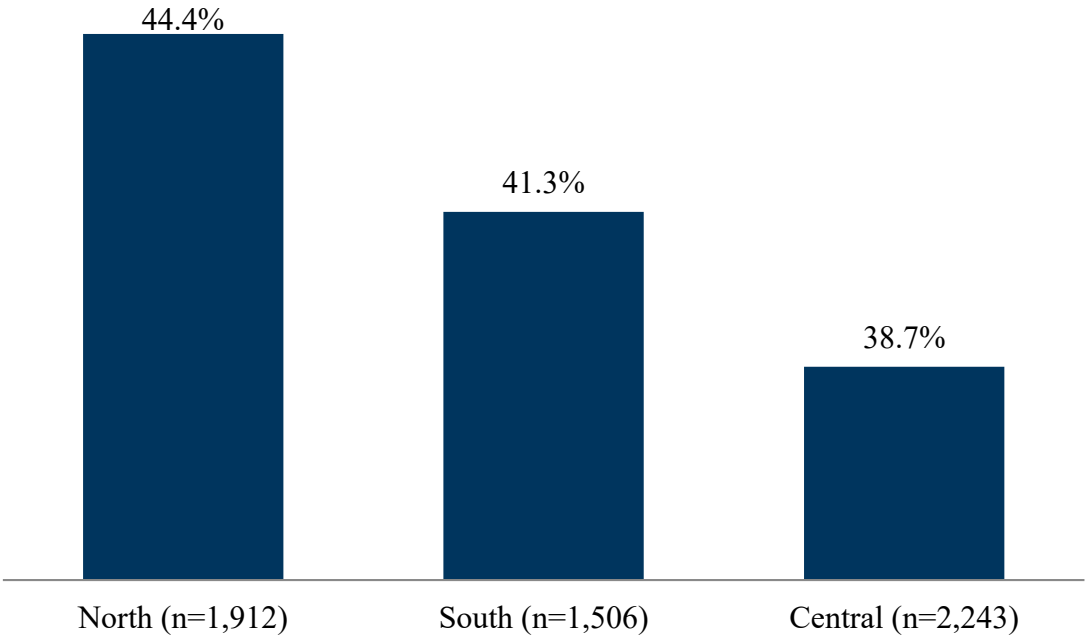


Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]

CalOptima Language:

CalOptima Language	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
English	43.8%	28.3%	6.6%	8.1%	258
Spanish	39.5%	17.6%	4.9%	12.2%	205
Vietnamese	26.6%	15.7%	5.0%	13.0%	338
Korean	64.2%	35.3%	4.1%	5.1%	391
Farsi	53.1%	23.8%	5.1%	8.1%	273
Arabic	62.9%	16.3%	1.8%	11.8%	221
Chinese	40.6%	21.1%	7.7%	14.1%	298
Other	33.1%	23.2%	5.5%	12.7%	181

Age Category:

CalOptima Age Category	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
0-5 (Children)	19.5%	23.7%	3.4%	14.4%	118
6-18 (Children)	34.7%	25.6%	1.8%	15.1%	219
19-64 (Adults/MCE)	52.7%	27.3%	4.1%	9.0%	1,062
65+ (Older Adults)	19.5%	23.7%	3.4%	14.4%	766

[17] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

[18] Only reported those who have not seen a dentist within the past 12 months.

Region:

CalOptima Region	Cost	Don't have/know dentist	No transportation	Don't know	n
	%	%	%	%	
North	48.9%	22.3%	5.5%	9.9%	798
South	51.6%	28.2%	4.6%	9.4%	585
Central	39.2%	20.9%	5.2%	11.3%	776

Exhibit 26. Days per week member had at least one drink of alcoholic beverage during the past 30 days [19]

CalOptima language:

CalOptima Language	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
English	71.7%	19.6%	4.0%	2.0%	2.7%	403
Spanish	83.5%	10.4%	1.3%	0.9%	3.9%	230
Vietnamese	81.3%	10.7%	1.9%	1.8%	4.3%	738
Korean	77.1%	15.5%	3.0%	1.5%	2.9%	593
Farsi	74.8%	19.3%	1.2%	0.2%	4.4%	497
Arabic	87.6%	4.5%	0.6%	0.8%	6.5%	355
Chinese	84.9%	8.0%	1.2%	0.6%	5.4%	503
Other	83.7%	7.7%	1.6%	1.3%	5.8%	312

Age Category:

CalOptima Age Category	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
19-64 (Adults/MCE)	78.7%	13.0%	2.3%	1.0%	4.9%	2,163
65+ (Older Adults)	82.2%	11.4%	1.4%	1.4%	3.5%	1,468

[19] Only reported those who are 18 years or older.

Region:

CalOptima Region	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
North	81.1%	11.9%	1.2%	1.5%	4.3%	1,156
South	79.5%	14.5%	1.8%	0.7%	3.5%	1,000
Central	79.7%	11.4%	2.5%	1.3%	5.1%	1,465

January 2018

CalOptima Member Survey Data Book:

Weighted Population Estimates

harder+co | community research

CalOptima A Public Agency Better. Together.

Navigating the Healthcare System

Exhibit 27. Percent who report at least one person as their doctor (n=5,749)

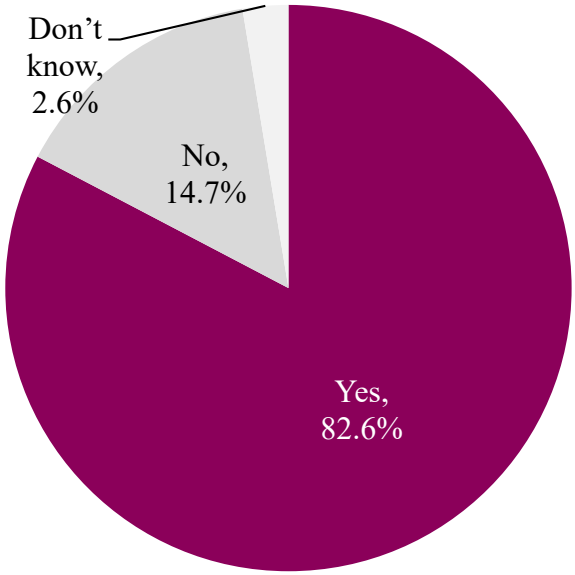


Exhibit 28. Where respondents go to see their doctor (n=5,743)

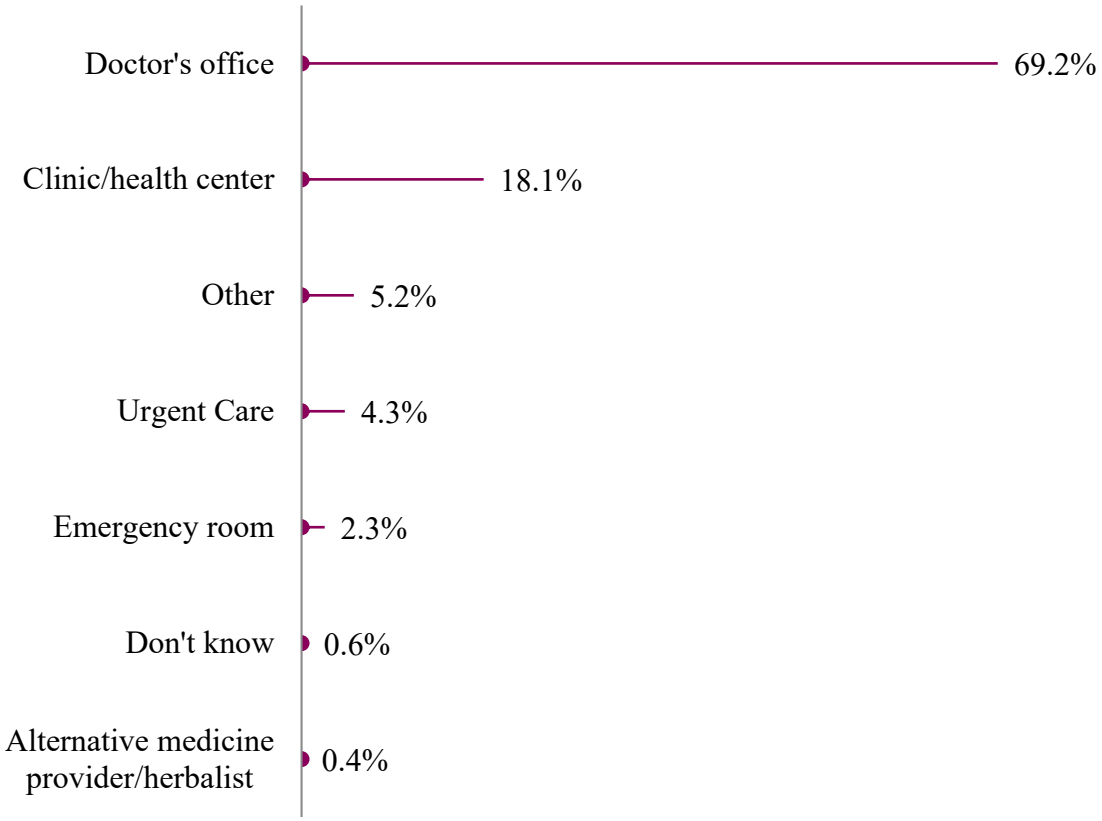


Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

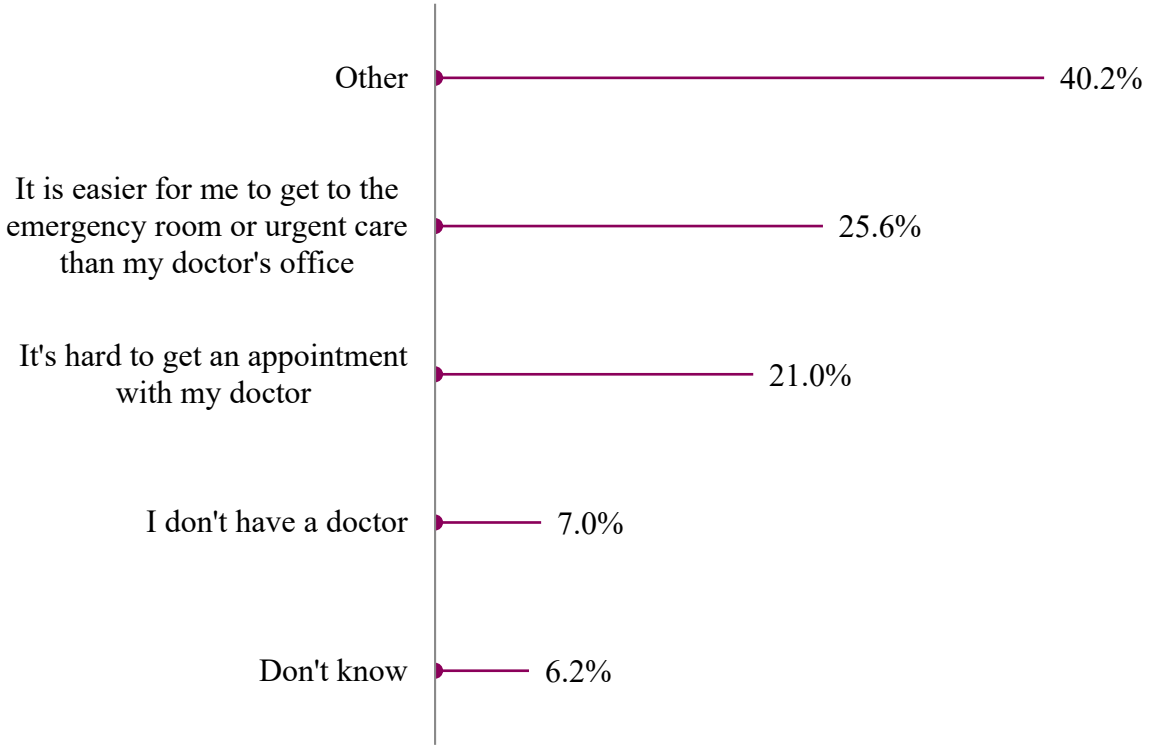


Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]

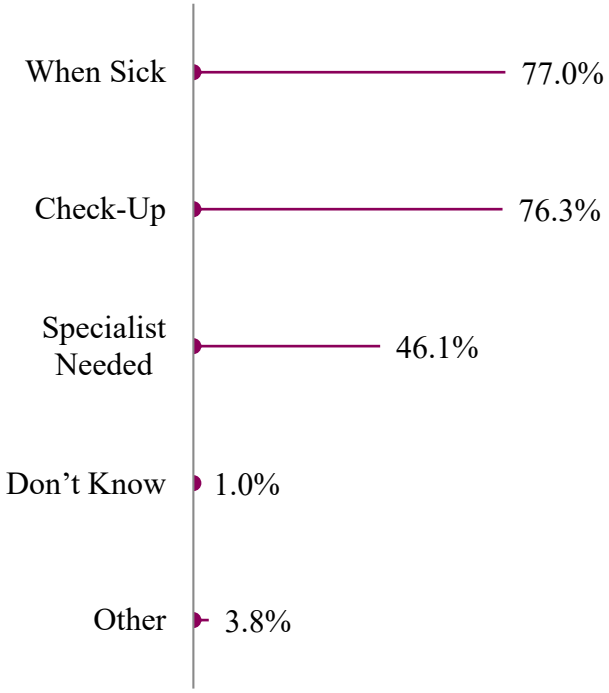
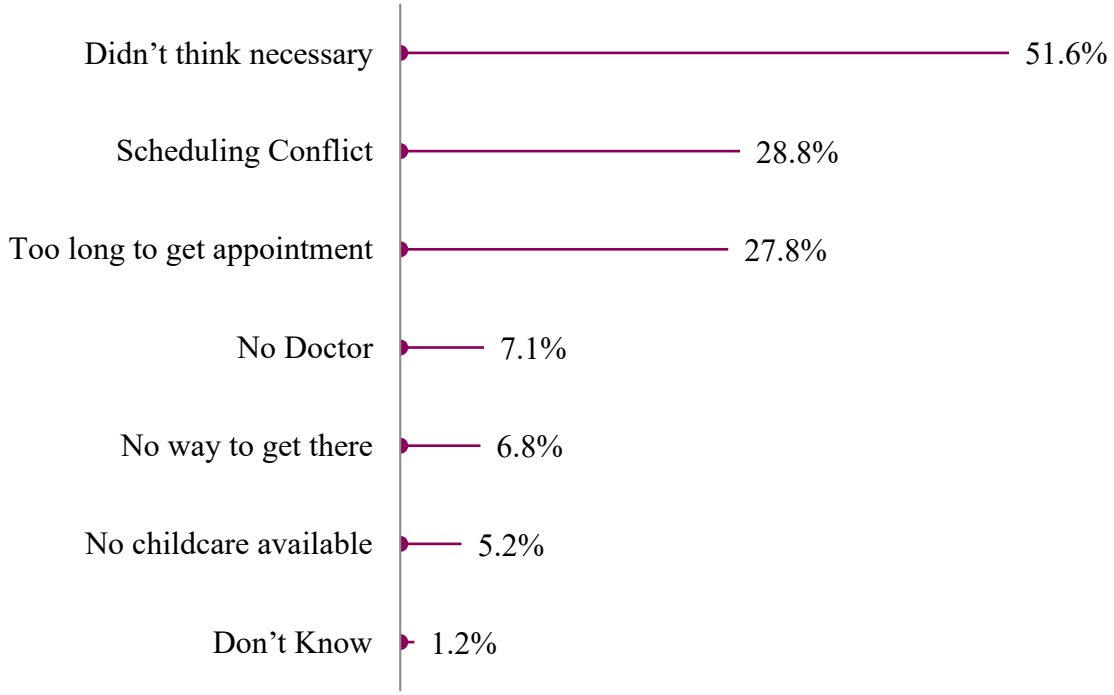


Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]



[20] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[21] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 32. When do members make an appointment to see a specialist (n=5,590)[22]

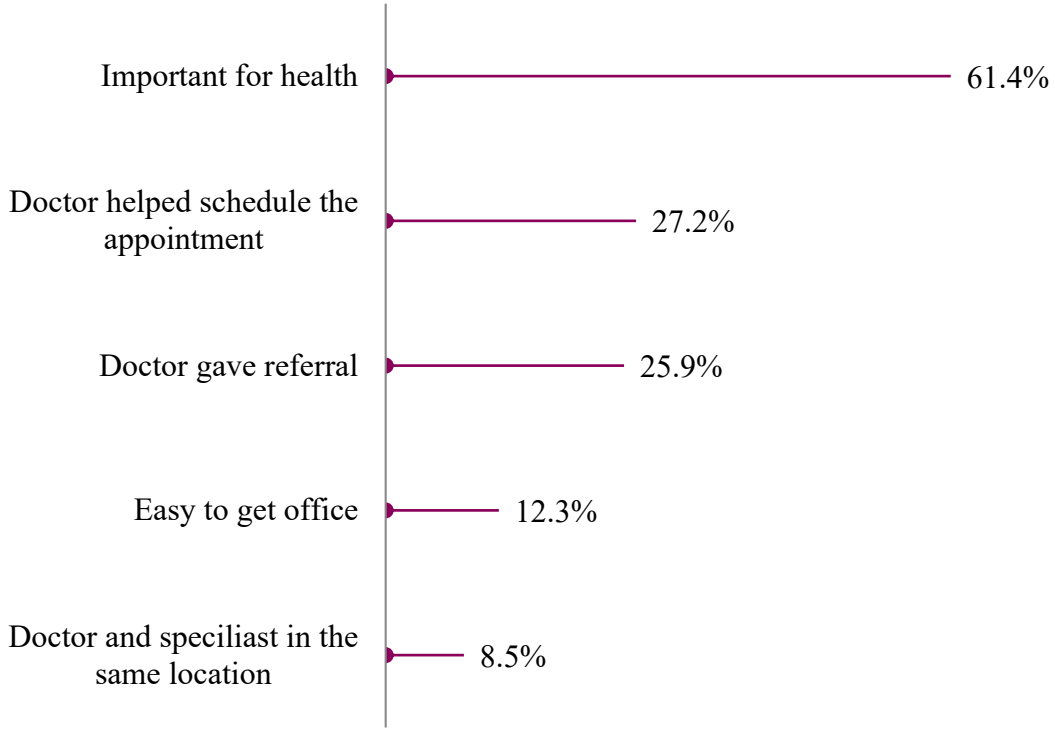
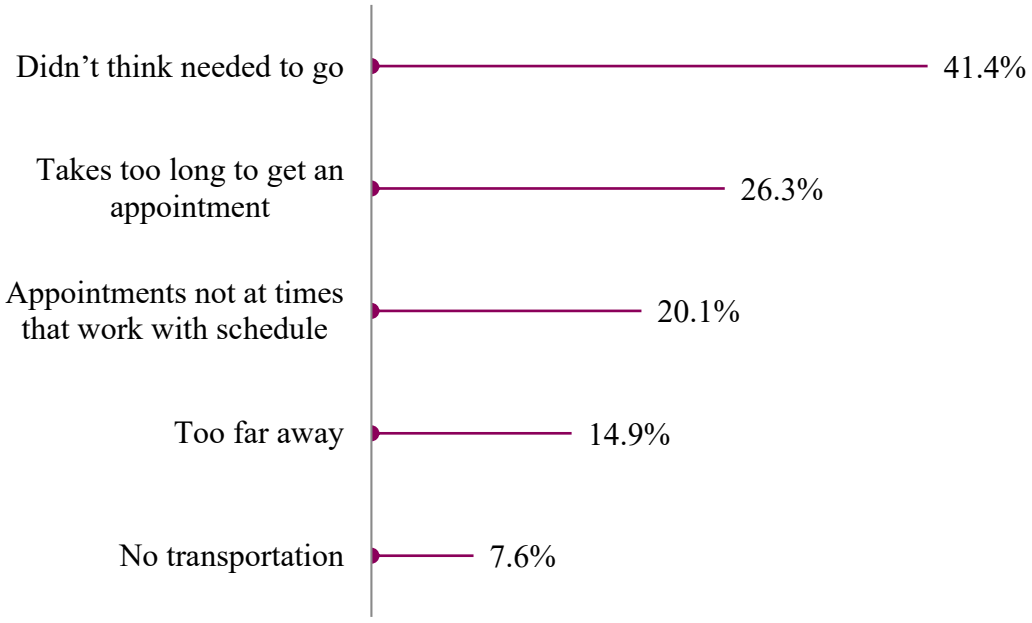
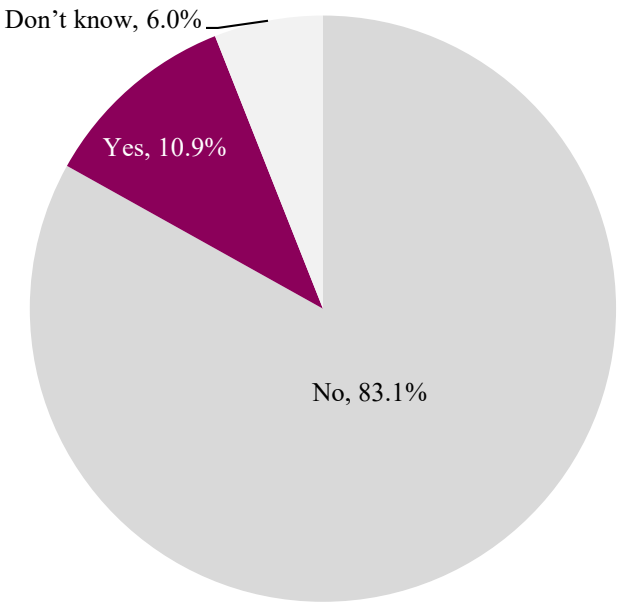


Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]



[22] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[23] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 34. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor (n=4,955)



Social and Emotional Well-Being

Exhibit 35. Percent of members who indicated they needed to see a mental health specialist (n=5,723)

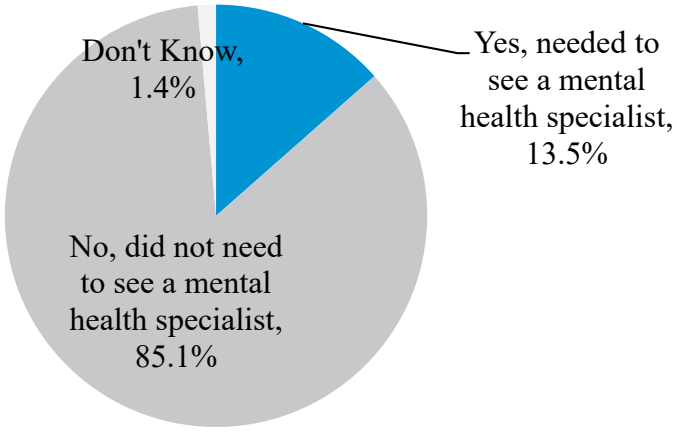


Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)

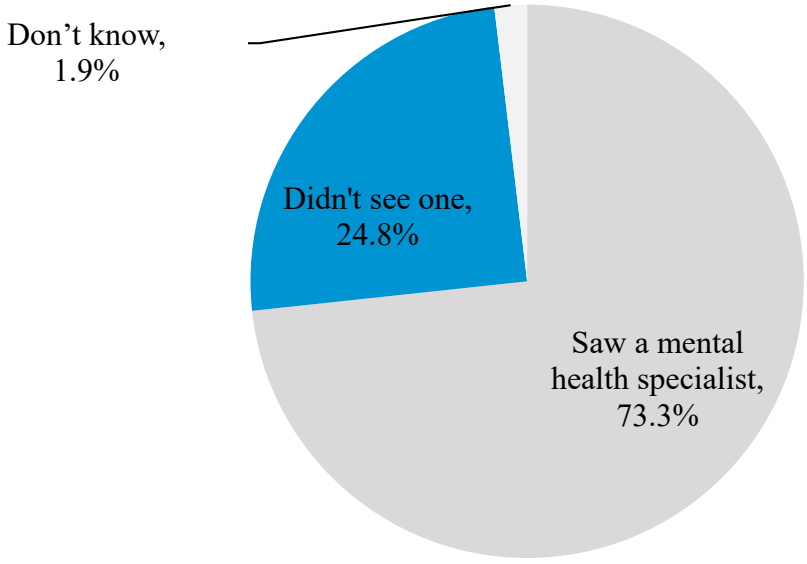


Exhibit 37. Reasons why members didn't see mental health specialist[24]

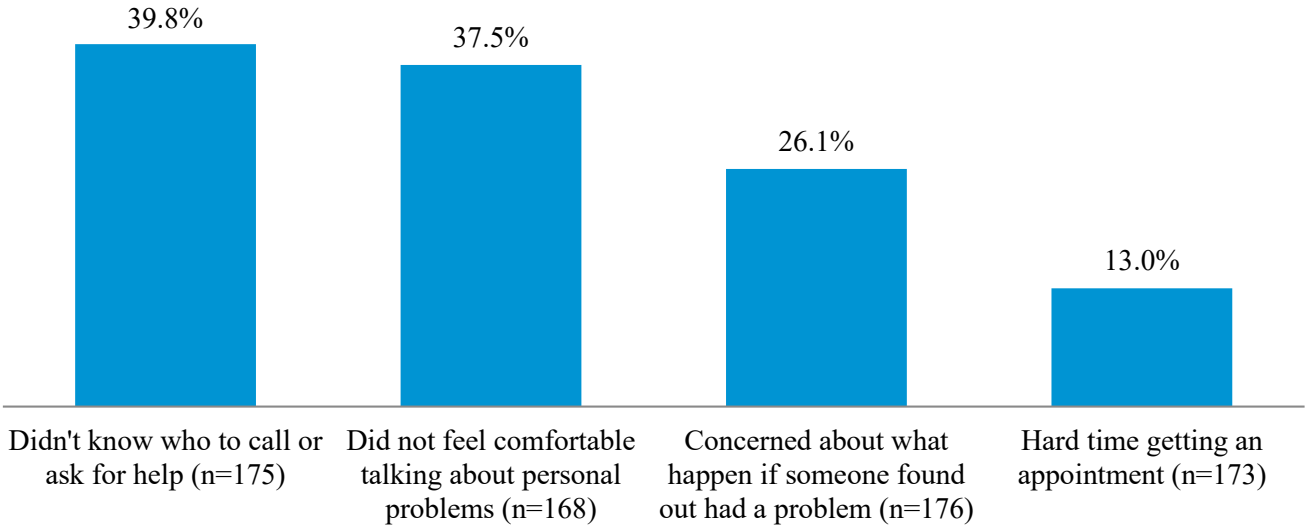
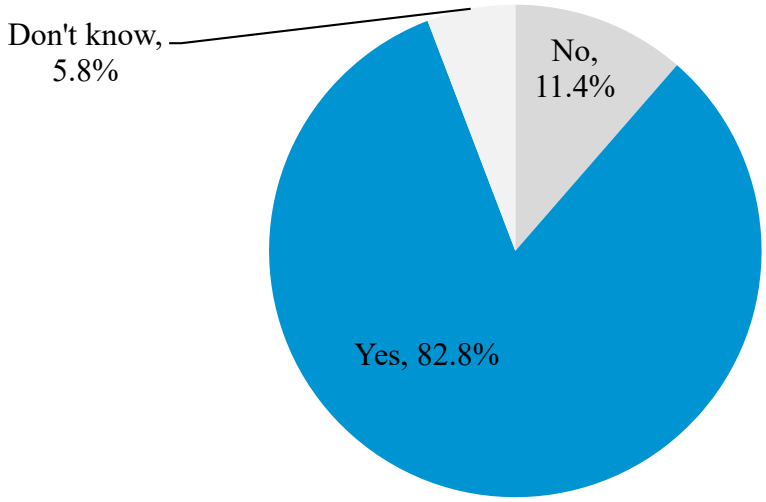


Exhibit 38. Percent of members who can share their worries with family members (n=5,670)



[24] Among those who indicated that they needed to see a mental health specialist but did not see one.

Social Determinants of Health

Exhibit 39. Percent of members who needed help with basic needs in the past 6 months:

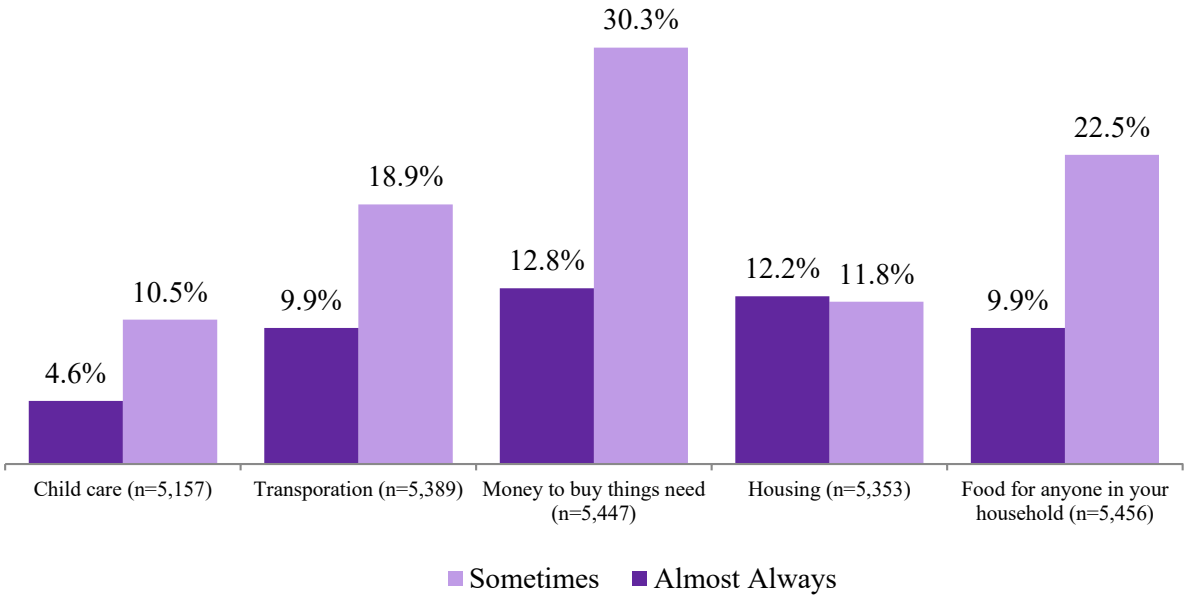


Exhibit 41. Percent of members who receive public benefits (n=5,117):

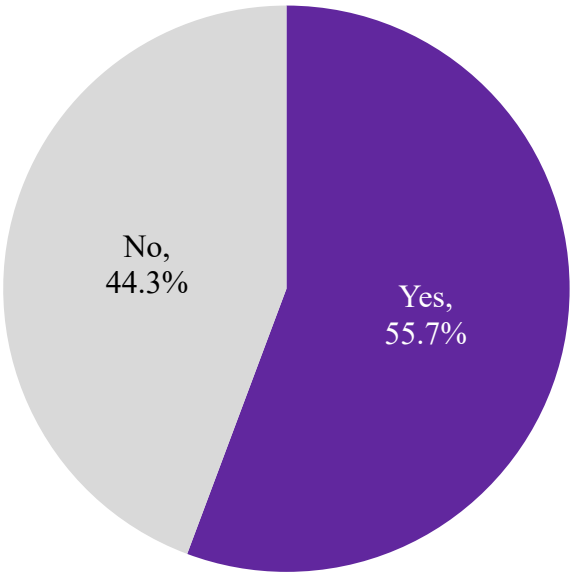
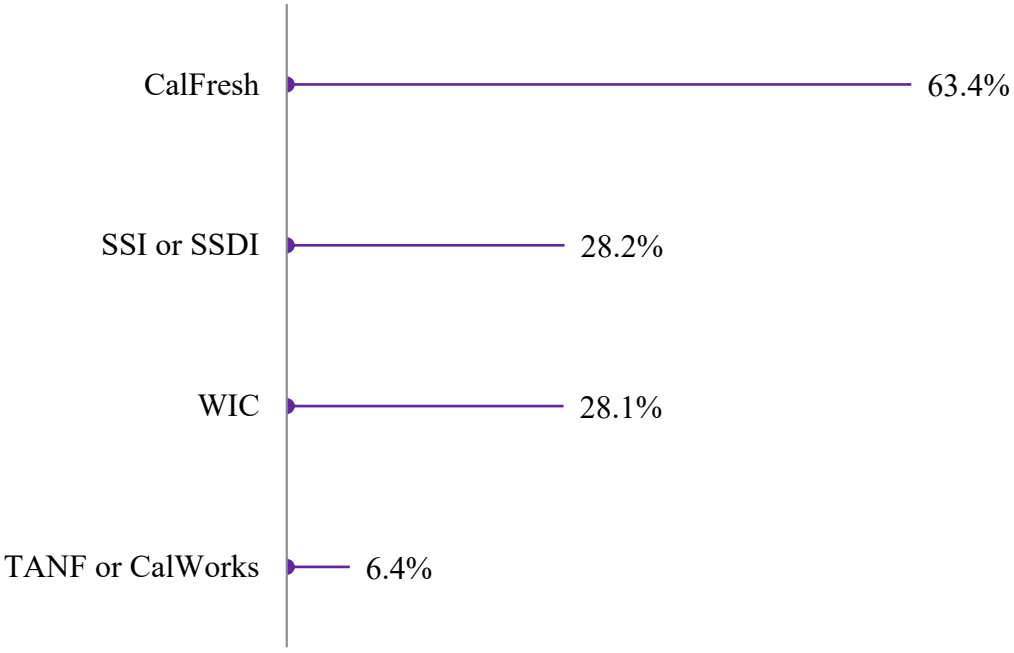


Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:

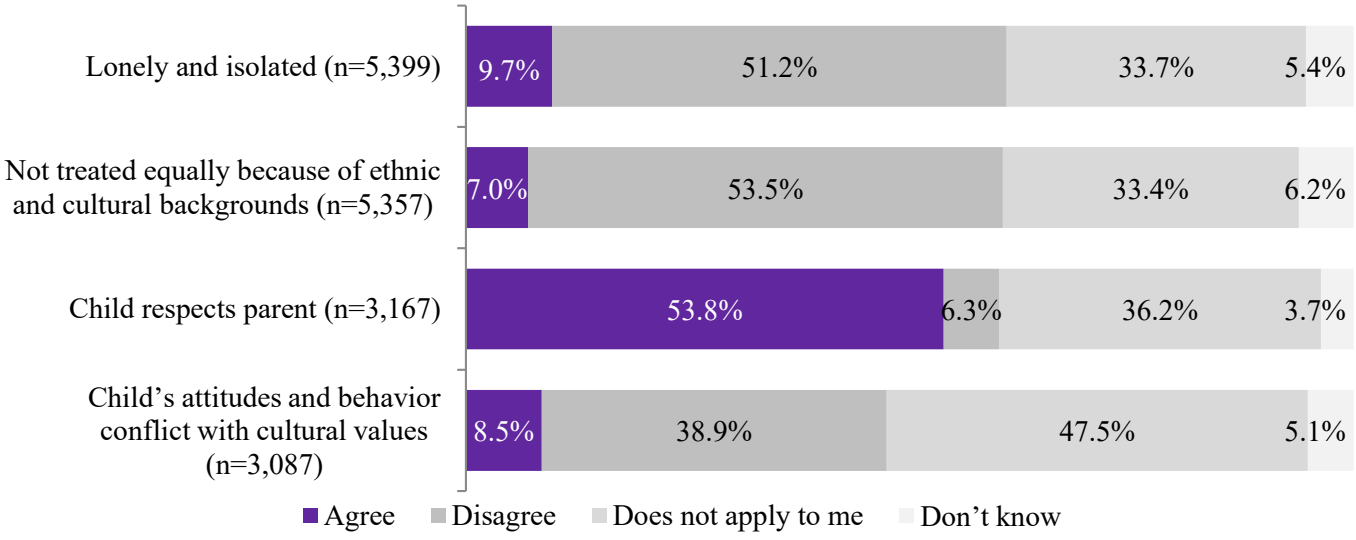


[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

Exhibit 43. Personal activities members participant in:

	Once a week	Once a month	Once in the last 6 months	Never	n
Care for a family member	36.2%	5.6%	5.1%	53.1%	5,209
Fun with others	61.9%	17.0%	6.6%	14.6%	5,396
Volunteer or Charity	16.4%	14.2%	17.3%	52.1%	5,288
Physical fitness	68.4%	10.2%	4.8%	16.7%	5,393
Attend religious centers	48.7%	11.1%	10.8%	29.4%	5,470
Get enough sleep	83.5%	5.8%	1.1%	9.6%	5,119
Enough time for self	77.4%	10.6%	3.1%	8.8%	5,209
Enough time for family	81.5%	8.5%	3.1%	6.9%	5,274
Gambling activities	0.9%	0.8%	4.8%	93.5%	5,378

Exhibit 44. Feelings towards community and home enviroment[26]:



[26] Only reported for those over 18 years old for "Child respects parent" and "Child's attitudes and behavior conflict with cultural values."

Exhibit 45. How well members speak English (n=5,549)

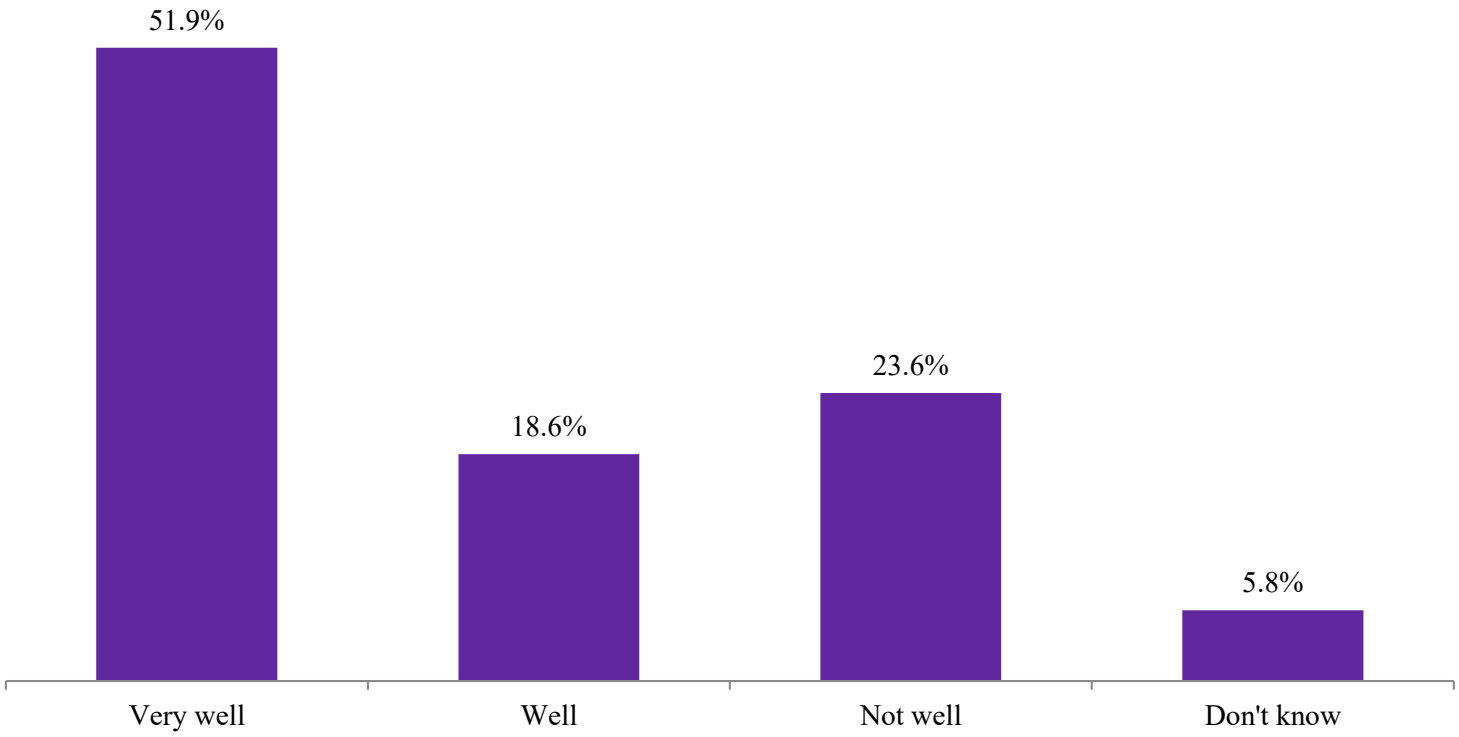


Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]

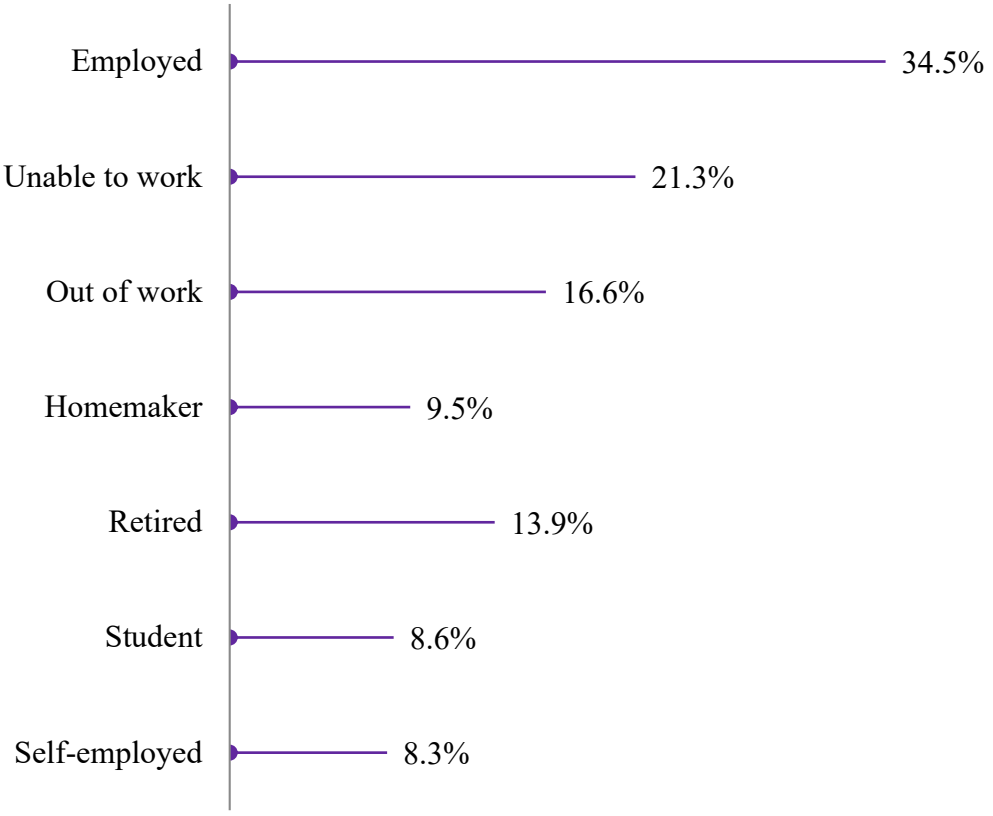
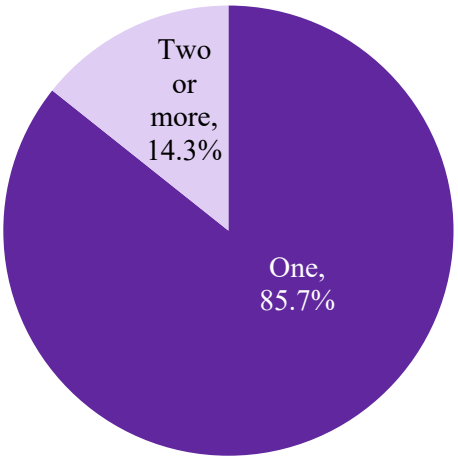
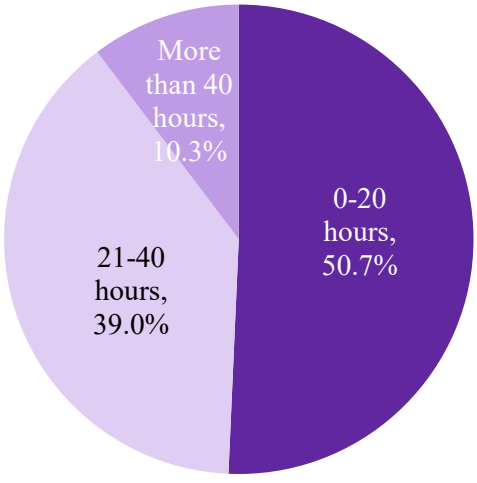


Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]

Number of jobs members have



Number of hours that members work each week



[27] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[28] Only reported the members who are over 18 years old.
[29] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

Exhibit 48. Members' living situation (n=5,590)

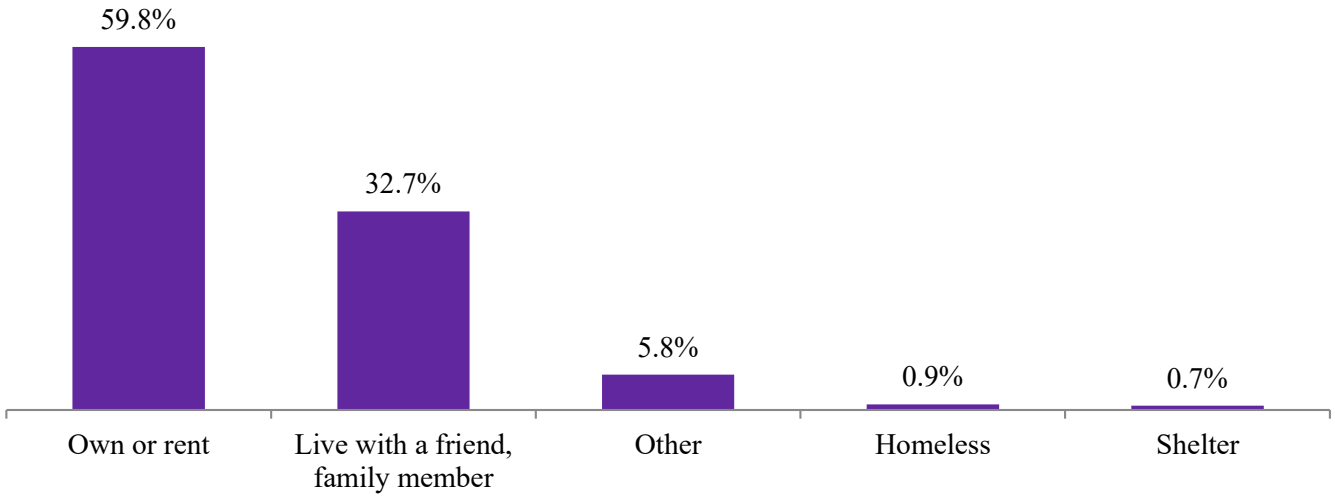
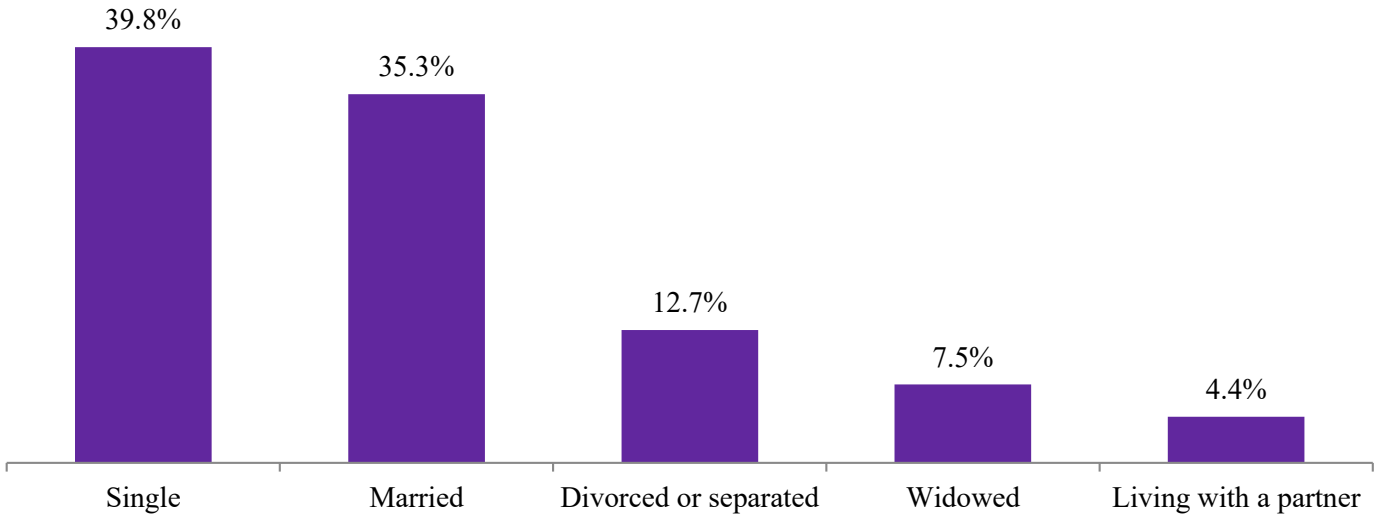


Exhibit 49. Marital status of members (n=3,271)[30]



[30] Only reported those who are over 18 years old.

Exhibit 50. Percent of members who were born in the United States (n=5,599)

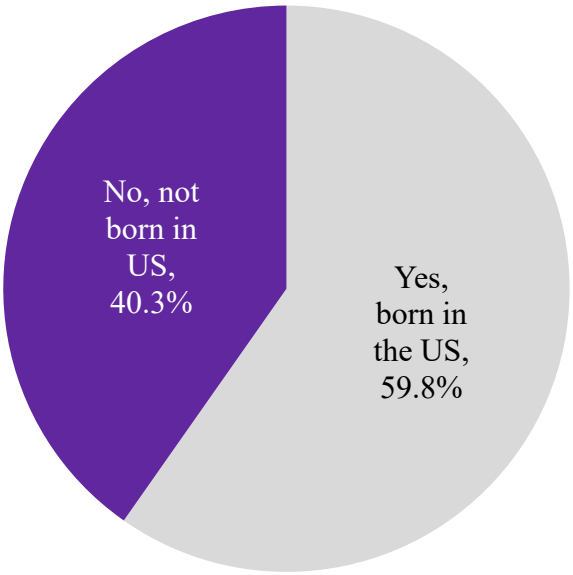
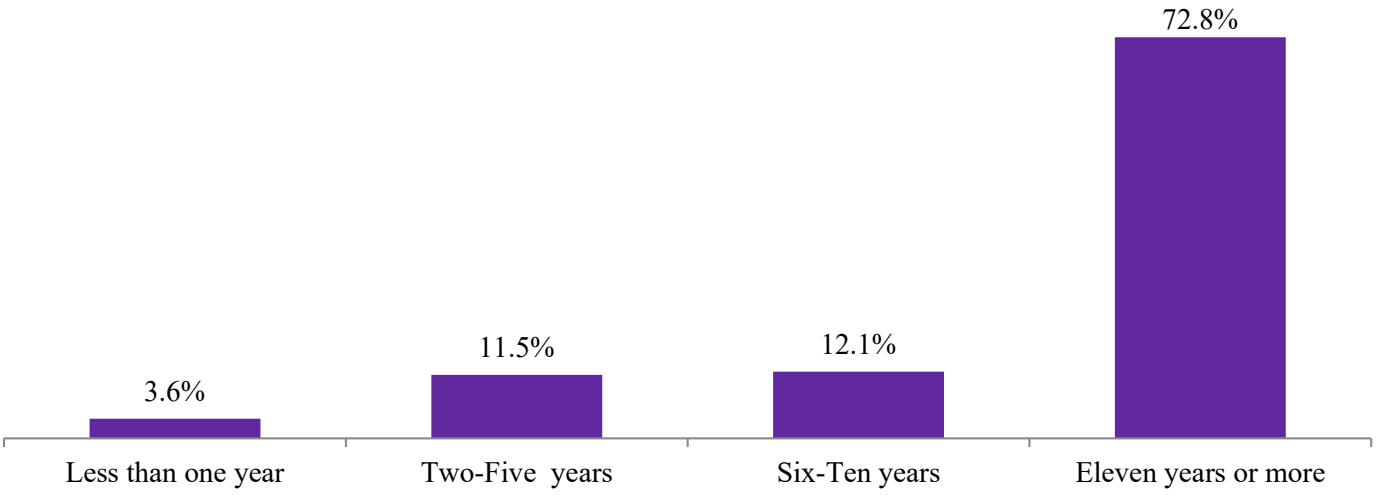


Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]



[31] Of those who were born outside of the U.S.

Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

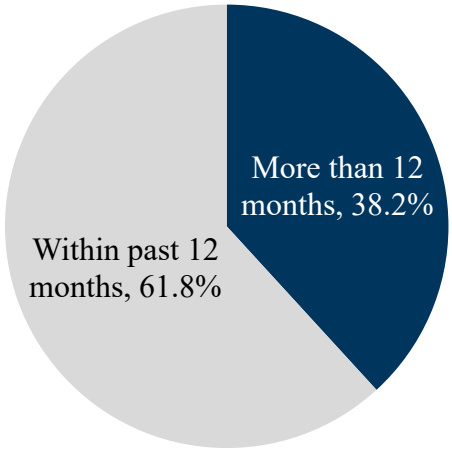
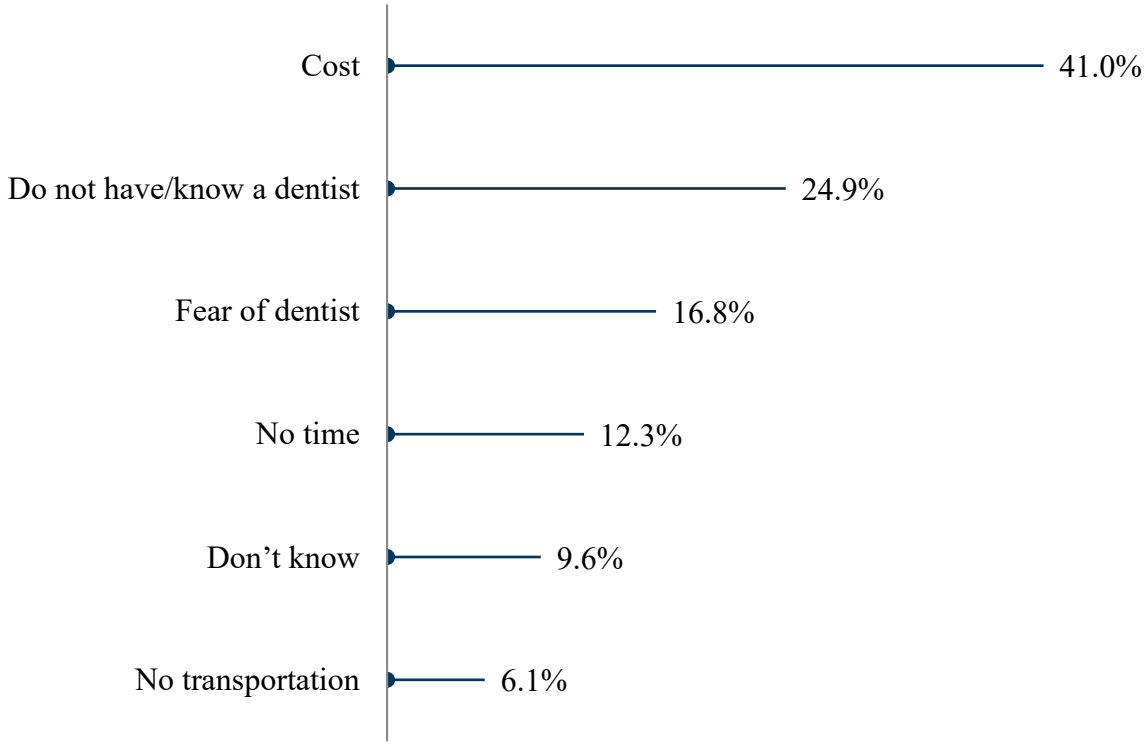
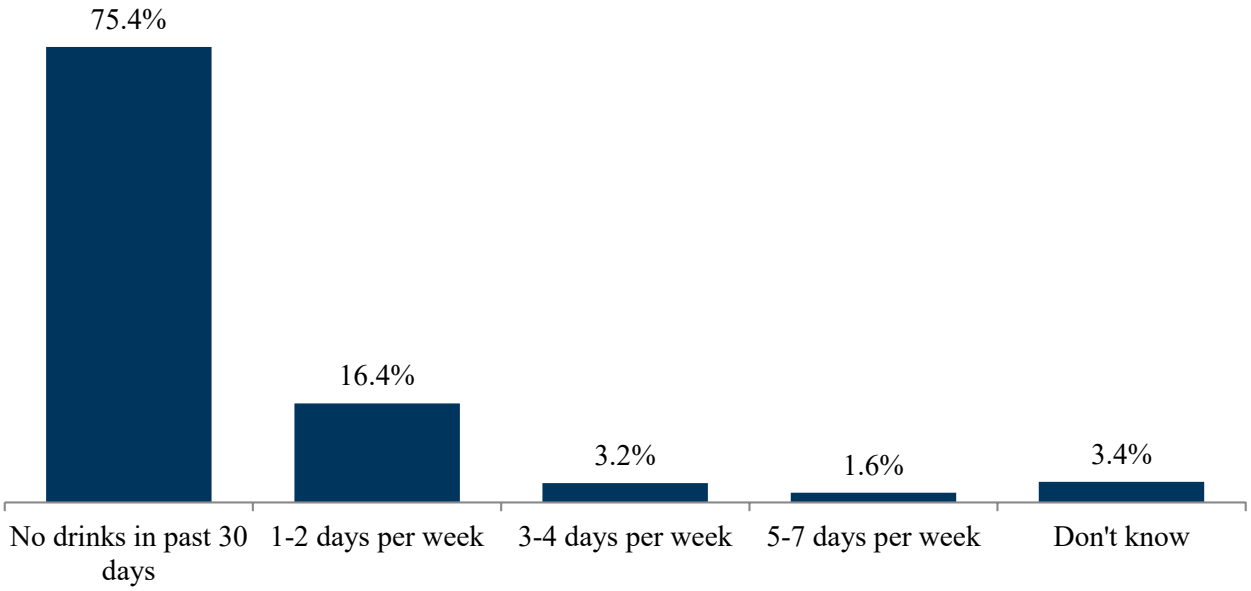


Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]



[32] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[33] Only reported those who have not seen a dentist within the past 12 months.

Exhibit 54. Days per week member had at least one drink of alcoholic beverage during the past 30 days (n=3,083)[34]



[34] Only reported those who are 18 years or older.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

41. Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

Authorize the release of Requests for Information (RFI) for the eight board-approved categories identified by the CalOptima Member Health Needs Assessment to develop specific Scopes of Work for full Requests for Proposal (RFP).

Background

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to award approximate $14.4 million in IGT 5 funds.

CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders.

At the February 1, 2018 Board of Directors meeting, staff presented the results and Executive Summary of the MHNA as well as requested authority to release Requests for Proposal (RFP) for community grants. From the information gathered, the MHNA identified eight board-approved categories as needs in the community. The eight board-approved categories include:

1. Expand Access to Mental Health Services for Adults
2. Expand Access to Mental Health and Socialization Services for Older Adults
3. Expand Access to Mental Health/Developmental Services for Children Ages 0-5
4. Expand Access to Nutrition Education and Fitness Programs for Children and their Families
5. Increase Medi-Cal Benefits Education and Outreach
6. Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health
7. Expand Access to Adult Dental Services
8. Expand Access to Children's Dental Services

Approval to release the RFPs was unanimous by the Board of Directors.

Back to Agenda

Discussion
In preparation for the release of the community grant RFPs, staff conducted a review of the descriptions for each of the eight categories identified by the MHNA. Staff recognized a need to narrow and better define a more precise and definitive Scope of Work (SOW) for each category. The specific SOWs for the RFPs will be developed based on the responses received from the RFI process. The RFI responses will be evaluated to select innovative ideas for services and programs to address the needs of CalOptima members. Staff will review the RFI responses and develop full RFPs so that interested community-based organizations, public agencies and other eligible entities can submit a proposal for consideration. More than one idea per category may be selected from the RFI responses and developed into a full RFP.

Staff is requesting authority to release RFIs for the eight board-approved categories that were identified through the MHNA. Staff will return to the Board for approval of the scopes of work developed in conjunction with the RFI and to release the RFPs.

Fiscal Impact
There is no fiscal impact to CalOptima's general operating budget.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima staff plans to work with our provider and community partners to address gaps in health care services for CalOptima members.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Board Action dated February 1, 2018, Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

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#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

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6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

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Member Health Needs Assessment

Board of Directors Meeting
February 1, 2018

Cheryl Meronk
Director, Strategic Development

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Member Health Needs Assessment

A better study offering deeper insight, leading to a healthier future.

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A Better Study

- ➔ More Comprehensive
- ➔ More Engaging
- ➔ More Personal

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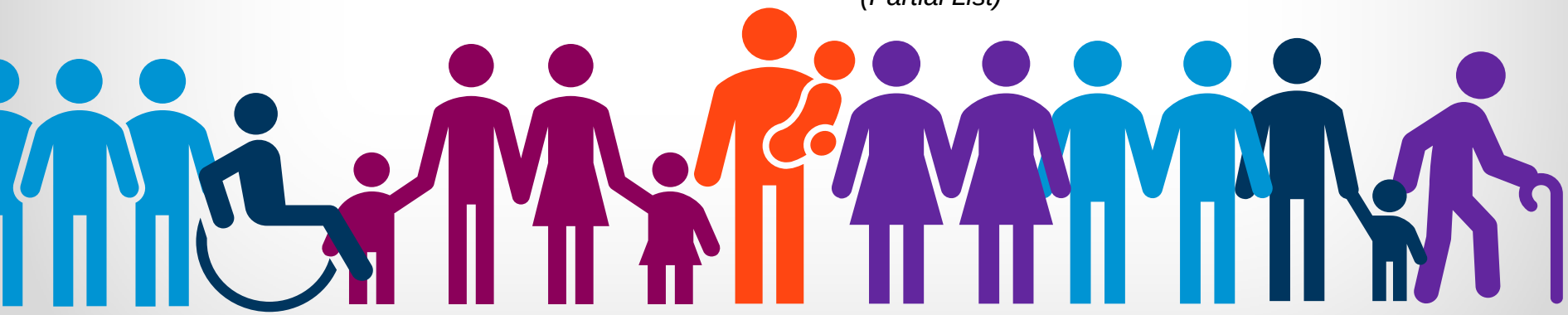
More Comprehensive

- Reached new groups of members whose voices have rarely been heard before
  - Young adults with autism
  - People with disabilities
  - Homeless families with children
  - High school students
  - Working parents
  - New and expectant mothers
  - LGBTQ teens
  - Homeless people in recuperative care
  - Farsi-speaking members of a faith-based group
  - PACE participants
  - Chinese-speaking parents of children with disabilities

(Partial List)



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More Comprehensive (Cont.)

- Gathered responses from all geographic areas of Orange County



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More Comprehensive (Cont.)

- Probed a broader view of members' lives beyond immediate health care needs
  - Hunger
  - Child care
  - Economic stress
  - Housing status
  - Employment status
  - Physical activity
  - Community engagement
  - Family relationships
  - Mental health
  - Personal safety
  - Domestic violence
  - Alcohol and drug consumption

(Partial List)



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More Comprehensive (Cont.)

- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In the past 12 months, did you have the need to see a mental health specialist?
  - How open are you with your doctor about your sexual orientation?
  - How sensitive are your health care providers in understanding your disability?

(Partial List)

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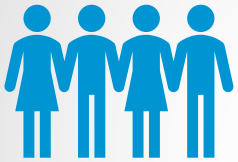
More Engaging: Members



Focus Groups

- 31 face-to-face meetings in the community
- 353 members



Telephone Conversations

- 534 live interviews in members' languages



Mailed Surveys

- Nearly 6,000 surveys returned



Electronic Responses

- More than 250 replied conveniently online

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More Engaging: Member Advocates

- Abrazar Inc.
- Access CA Services
- Alzheimer's OC
- Boys & Girls Club
- The Cambodian Family
- CHOC
- Dayle McIntosh
- La Habra Family Resource Center
- Latino Health Access
- Korean Community Services
- Mercy House
- MOMS Orange County
- OMID
- SeniorServ
- South County Outreach
- State Council on Developmental Disabilities
- Vietnamese Community of OC Inc.

(*Partial List)*

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More Personal

- Met in familiar, comfortable locations at convenient times for our members
  - Apartment complexes
  - Churches
  - Community centers
  - Schools
  - Homeless shelters
  - Recuperative care facilities
  - PACE center
  - Community clinics
  - Restaurant meeting rooms



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More Personal (Cont.)

- We spoke their language
  - English
  - Spanish
  - Vietnamese
  - Korean
  - Farsi
  - Chinese
  - Arabic
  - Cambodian
  - Marshallese
  - American Sign Language

The Voice of the Member

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Offering Deeper Insight

- → Barriers to Care
- → Lack of Awareness About Benefits and Resources
- → Negative Social and Environmental Impacts

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Notable Barriers to Care

- Study revealed that members encounter structural and personal barriers to care
  - Structural
    - It can be challenging to get an appointment to see a doctor
    - It takes too long to get an appointment
    - Doctors do not always speak members' languages
    - Interpreter services are not always readily available
    - Doctors lack understanding of members' cultures
  - Personal
    - Members don't think it is necessary to see the doctor
    - Members have personal beliefs that limit treatment
    - Members are concerned about their immigration status
    - Members are concerned someone would find out they sought mental health care

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Barriers to Care (Cont.)

Examples

52%

Don’t think it is necessary to see the doctor for a checkup

28%

Takes too long to get an appointment

26%

Concerned someone would find out about mental health needs

41%

Didn’t think it is necessary to see a specialist, even when referred

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Notable Lack of Awareness

- Survey revealed a lack of understanding about available benefits and services
  - 25 percent of members who needed to see a mental health specialist did not pursue treatment
  - 38 percent of members had not seen a dentist in more than a year

- Focus group participants commented frequently about having difficulty regarding certain resources
  - Interpreter services
  - Social services needs
  - Transportation

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Lack of Awareness (Cont.)

Examples

40%

Didn't know who to ask for help with mental health needs

41%

Didn't see a dentist because of cost (i.e., didn't know dental care was covered)

25%

Don't have or know of a dentist

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Negative Social and Environmental Impacts

- Survey revealed significant social and environmental difficulties
  - Lack of well paying jobs and employment opportunities
  - Lack of affordable housing
  - Social isolation due to cultural differences, language barriers or fear of violence
  - Economic insecurity and financial stress
  - Lack of walkable neighborhoods and the high cost of gym programs

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Negative Impacts (Cont.)

Examples

32%
Needed help getting food in the past six months

56%
Accessing other public assistance

43%
Needed help to buy basic necessities

29%
Needed help getting transportation

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Negative Impacts (Cont.)

Stakeholder Perspective

> There's a significant issue with improper nutrition. They may not have enough money or the ability to go to the grocery store to buy the right foods. They get what they can, and that's what they eat.
>
> *—Interviewee*

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Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

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Funding

$14.4 Million

Total Available IGT 5 Funds

- **Member Health Needs Assessment results drive funding allocations**

- **Eight Requests for Proposal (RFPs) to expand access to mental health, dental and other care, and outreach/education services**

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RFP 1

Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $5 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category
Adult Mental Health

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RFP 2

Expand Mental Health and Socialization Services for Older Adults

Funding Amount: $500,000

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category
Adult Mental Health

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RFP 3

Expand Access to Mental Health/ Developmental Services for Children 0–5 Years

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Shortage of pediatric mental health professionals
- ✓ Shortage of children's inpatient mental health beds
- ✓ Increase in adolescent depression

Funding Category
Children's Mental Health

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RFP 4

Nutrition Education and Fitness Programs for Children and Their Families

Funding Amount: $1 million

Findings Addressed

- ✓ Healthier food choices can be more expensive, less convenient and less accessible
- ✓ Cultural foods may not be the healthiest options
- ✓ Lack of time and safe places may limit physical activity

Funding Category
Childhood Obesity

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RFP 5

Medi-Cal Benefits Education and Outreach

Funding Amount: $500,000

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits

Funding Category

Supporting the Safety Net

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RFP 6

Expanded Access to Primary Care and Programs Addressing Social Determinants of Health

Funding Amount: $4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Lack of ability to cover basic necessities

Funding Category
Supporting the Safety Net

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RFP 7

Expand Adult Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1.4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Limited dental providers for adults

Funding Category
Supporting the Safety Net

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RFP 8

Expand Access to Children's Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not utilizing covered services
- ✓ Challenging to get an appointment to see a provider

Funding Category
Children's Health

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Moving Forward

- Eight Grant Applications/RFPs
  - Expand access to mental health, dental and other care services
  - Expand access to childhood obesity services regarding nutrition and fitness
  - Support outreach and education regarding social services and covered benefits
- RFPs to be released in March 2018
- Recommended grantees to be presented at June Board meeting

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EXECUTIVE SUMMARY
MEMBER HEALTH NEEDS ASSESSMENT

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In summer and fall 2017, more than 6,000 CalOptima members, service providers and community representatives participated in one of the most extensive and inclusive member health needs assessments (MHNA) undertaken by CalOptima in its 20-plus year history. The MHNA provides data critical to ensuring that CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima participates in numerous efforts to assess the health of Orange County's residents and create community-driven plans for improving the health of the Medi-Cal population. Some examples are detailed below.

- The 2013 Orange County Health Profile, produced by the Orange County Health Care Agency, highlighted key health indicators as well as other social, economic and environmental indicators that impact health conditions in groups of people based on economics, race, ethnicity, gender, age and geography.
- The 2016 Orange County Community Indicators Report tracked and analyzed Orange County's health and prosperity on a myriad of issues.
- The 2017 Conditions of Children in Orange County Report offered a comprehensive and detailed summary of how children in Orange County fair in the areas of health, economic well-being, educational achievement, and safe homes and communities.
- CalOptima's Group Needs Assessment, conducted every five years with annual updates in between, identifies members' needs, available health education, cultural and linguistic programs, and gaps in services.

When combined, these assessments provide a broad picture of important health information in Orange County. However, they do not focus specifically on Medi-Cal beneficiaries or on ethnic and linguistic minorities within this population, whose health needs are at the core of CalOptima's mission. For this reason, CalOptima undertook this comprehensive MHNA, summarized on the following pages.

By the Numbers

5,815
Surveys

31
Focus Groups

24
Stakeholder Interviews

21
Provider Surveys

10
Languages

Birth–101
Years of Age

Back to Agenda

CalOptima's comprehensive MHNA is an innovative collaboration that builds upon existing data-gathering efforts and takes them a step further. The study was designed to be a more comprehensive assessment, using engaging methods that resulted in a much more personal experience for our members and the community. The MHNA captures the unique and specific needs of Medi-Cal beneficiaries from an array of perspectives, including providers, community leaders and, most importantly, the members themselves. As a result, this in-depth study offers actionable recommendations for consideration by the CalOptima Board of Directors and executive leadership.

The MHNA was designed to help CalOptima identify:

1. Unique needs and challenges of specific ethnic communities, including economic, social and environmental stressors, to improve health outcomes

2. Challenges to health care access and how to collaborate with community-based organizations and providers to address these barriers

3. Member awareness of CalOptima services and resources, and effective strategies to increase awareness as well as disseminate information within target populations

4. Ways to leverage outreach efforts by partnering with community-based organizations on strategic programs

Our Partners

To guide the direction of the study, CalOptima established an MHNA Advisory Committee made up of community-based representatives. The committee then engaged CalOptima staff and Harder+Company Community Research (Harder+Company), in partnership with the Social Science Research Center (SSRC) at California State University, Fullerton. A summary of their qualifications to participate in this extensive effort is below.

Harder+Company was founded in 1986 and works with philanthropic, nonprofit and public-sector clients nationwide to reveal new insights about the nature and impact of clients' work. Harder+Company has a deep commitment to lifting the voices of marginalized and underserved communities — and working across sectors to promote lasting change. In addition, Harder+Company offers extensive experience working with health organizations to plan, evaluate and improve services for vulnerable populations, along with deep experience assisting hospitals, health departments and other health agencies on a variety of efforts, including conducting needs assessments, engaging and gathering meaningful input from community members, and using data for program development and implementation.

SSRC was established in 1987 to provide research services to community organizations and research support to university faculty. The center's primary goal is to assist nonprofit and tax-supported agencies and organizations to answer research questions that will lead to improved service delivery and public policy. The SSRC conducts surveys, evaluation research and other applied research activities to meet its clients' information needs. The center conducts multilingual telephone surveys from its 24-station computer-assisted telephone interviewing lab, as well as web-based, mailed and face-to-face surveys. In the past 10 years, SSRC has successfully completed 200 telephone survey projects using a variety of sample designs in diverse areas of focus, such as health care, public safety, education, workforce development and pregnancy prevention.

harder + co | community research

CALIFORNIA STATE UNIVERSITY FULLERTON

Due to strong partnerships with the community, the 2017 MHNA engaged members who may be hard to reach. We are proud that our efforts included:

- Young adults on the autism spectrum
- People with disabilities
- Homeless families and children
- High school students
- Working parents
- New and expectant mothers
- LGBTQ teens
- Farsi-speaking members of faith-based groups
- PACE participants
- Chinese-speaking parents of children with disabilities

More Comprehensive

To represent CalOptima's nearly 800,000 members, an in-depth analysis was performed to uncover their unique needs and challenges. An oversampling was thoughtfully incorporated in the calculation of responses needed to achieve a true statistical representation of the Orange County Medi-Cal population. For the mailed survey, more than 42,000 members were selected within a specific sampling frame that included language, age range and region.

With the oversampling, the aim was to collect 4,000 responses with targets for each subgroup. The final data collection results were far beyond the goal in every subgroup. More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

The assessment gathered responses from all geographic areas of Orange County, across all age groups and 10 languages. Additionally, the assessment reached new groups of members whose voices have rarely been sought out or heard before, such as young adults with autism, people with disabilities and homeless families with children.

Ultimately, the assessment concentrated on the underlying social determinants of health that have been recognized as factors that impact the health of individuals. The MHNA probed a broader view of members' lives beyond immediate health care needs to explore issues related to:

- ☑ Hunger
- ☑ Child care
- ☑ Economic stress
- ☑ Housing status
- ☑ Employment status
- ☑ Physical activity
- ☑ Community engagement
- ☑ Family relationships
- ☑ Mental health
- ☑ Personal safety
- ☑ Domestic violence
- ☑ Alcohol and drug use

More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

More Engaging

The MHNA used a mixed-methods approach to engage members who generally have been underrepresented in previous assessments as well as community stakeholders who work directly with the Medi-Cal population. The data collection effort was extensive, incorporating both qualitative and quantitative methods and going beyond previous processes in Orange County. The mixed-methods approach consisted of the following:

Member Survey

5,815 members completed an in-depth 50-question survey that was available in each of CalOptima's seven threshold languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic. As described further below, three additional languages that are less common in Orange County were also incorporated to ensure the assessment was comprehensive. Most surveys were completed and returned via mail (86 percent), with 9 percent completed via telephone and 5 percent online. Telephone calls were made to reach members who were homeless or more transient and may not have a permanent address. An online survey was offered for members' convenience.

Provider Survey

An online survey of 20 questions was sent to a broad sample of providers in CalOptima's network to seek insight on the challenges that members face. Providers identified what they perceive as the top problems for Medi-Cal members as well as barriers for these members in accessing health care. There were 21 network or physician medical groups that completed the provider survey.

Focus Groups

31 focus groups were conducted with members in partnership with community-based organizations across Orange County. Focus groups allowed for face-to-face conversations with members in comfortable and familiar environments, which helped to foster organic, open-ended discussions where members felt safe to share their thoughts. The discussions were conducted in CalOptima's seven threshold languages, as well as Cambodian, Marshallese and American Sign Language. Focus group conversations covered numerous key topics, including quality of life, community assets, barriers to accessing care, violence, behavioral health, chronic disease, and health practices, such as healthy eating and active living.

Key Stakeholder Interviews

24 leaders from community-based organizations participated in the interviews. Those chosen for the study have direct interactions with Medi-Cal members or serve as advocates for Orange County's vulnerable population. Interviews focused on key health issues facing Medi-Cal members, the provision of culturally competent services, and the social determinants of health, such as economic and environmental factors.

In the spirit of collaboration, individuals and groups in the community came together in a remarkable way to demonstrate their dedication to CalOptima members. Countless hours were spent planning, engaging and meeting with members. For example, in addition to serving as stakeholder interviewees, many of CalOptima's community partners reached out to members to encourage them to respond to the surveys, and they also hosted and recruited members to focus group meetings. Community organizations were invaluable in helping members feel comfortable with the process and in providing another view into members' lives. The engagement of community partners and member advocates was instrumental in the success of the MHNA.

More Personal

The MHNA aimed to give CalOptima members a more personal experience by hosting focus group conversations in familiar locations at convenient times, often evenings and weekends. These settings were intentionally selected based on members' comfort levels. Focus groups were also held at specific times to ensure that members could have their voices heard without having to miss work, school or other obligations. Focus groups were conducted in 10 languages enabling members to respond in their preferred spoken language.

Focus groups were held at:

- Apartment complexes
- Churches
- Community centers
- Schools
- Homeless shelters
- Recuperative care facilities
- PACE center
- Community clinics
- Restaurant meeting rooms

Methods

With a strong focus on engaging a representative sample of CalOptima members, Harder+Company and SSRC developed the sample frame to capture a breadth of perspectives as well as focus on the specific needs of key populations. Although the purpose of the MHNA was to assess the needs of Medi-Cal members in Orange County overall, Harder+Company and SSRC sought to gain a better understanding of the needs of CalOptima's non-English speakers by purposefully oversampling all seven subgroups. The oversampling of members designated as speaking one of the seven threshold languages ensured that CalOptima and community stakeholders can be 95 percent confident that the true population parameters for any particular subgroup will fall between +/- 5 percent of the observed sample estimate.

At more than 5,800 members, the survey response far exceeded the target number of respondents in the sampling frame. The robust response was due to a comprehensive data collection plan that included communication with members and partners in advance of sending the survey, reminder phone calls and multilingual computer-assisted telephone interviewing for members preferring to respond by phone.

Survey data was entered, monitored and quality checked by SSRC before being exported for analysis by Harder+Company. All variables were screened to determine the amount of missing data, and basic frequencies were initially computed for each question by language, region and age. To adjust for the oversampling built into the sampling frame, comprehensive statistical analysis was then completed applying weights calculated by SSRC. Additional analysis included collapsing of questions, construction of scale scores and cross-tabulations.

Exhibit 1: Distribution of Completed Surveys and CalOptima Population by Language, Region and Age

Language	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
English	658	11.3%	55.5%
Spanish	715	12.3%	28.6%
Vietnamese	981	16.9%	10.3%
Korean	940	16.2%	1.4%
Farsi	743	12.8%	1.1%
Arabic	648	11.1%	0.6%
Chinese	731	12.6%	0.5%
Other	399	6.9%	2.0%

Region	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
Central	2,315	39.8%	51.5%
North	1,947	33.5%	32.4%
South	1,538	26.4%	15.1%
Out of County	15	0.3%	1.0%

Age	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
0–18 years old	1,665	28.6%	41.8%
19–64 years old	2,453	42.2%	47.2%
65 or older	1,697	29.2%	10.9%

KEY FINDINGS

Given the scope and depth of the study, the MHNA revealed many key findings, which will all be included in the final, comprehensive report. This Executive Summary shares five **key findings**, including related **bright spots** and **opportunities**. Bright spots are CalOptima and community-based resources that already serve to support health behaviors and outcomes. CalOptima can nurture, leverage and build upon these assets. **Opportunities** are areas that CalOptima and its partners can strengthen to positively impact the health and well-being of members.

KEY FINDING: SOCIAL DETERMINANTS OF HEATLH

Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

Given that Medi-Cal eligibility is income-based, it is not surprising that many CalOptima members struggle with economic insecurity. In fact, 55.7 percent of members receive some form of public benefits (Exhibit 2). Further, in the past six months, more than one-quarter of members indicated they needed help with food (32.4 percent), housing (24 percent), money to buy things they need (43.1 percent) and transportation (28.8 percent) (Exhibit 3). Economic stress and financial insecurity cause members and their families to make tradeoffs, such as living in more dense and overcrowded housing with limited space for play and exercise, buying cheaper but less healthy food, or not going to the doctor despite wanting to.

Exhibit 2: Percent of members who receive public benefits (n=5,117)

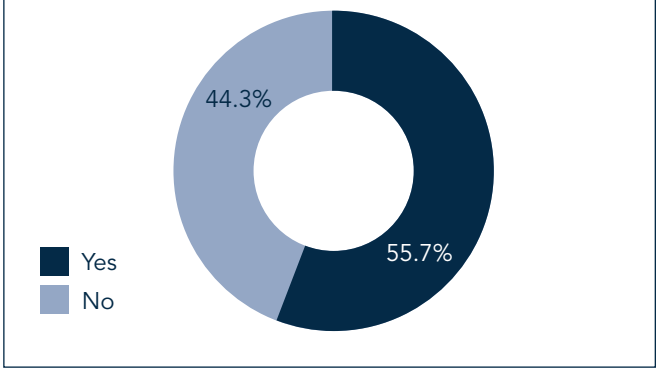
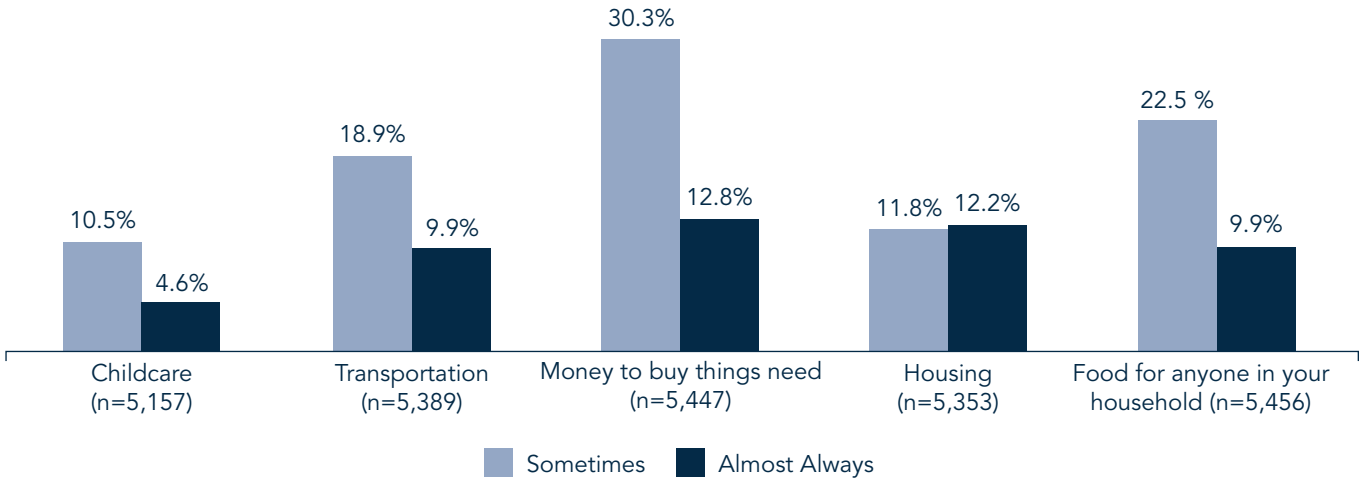


Exhibit 3: Percent of members who needed help with basic needs in the past six months



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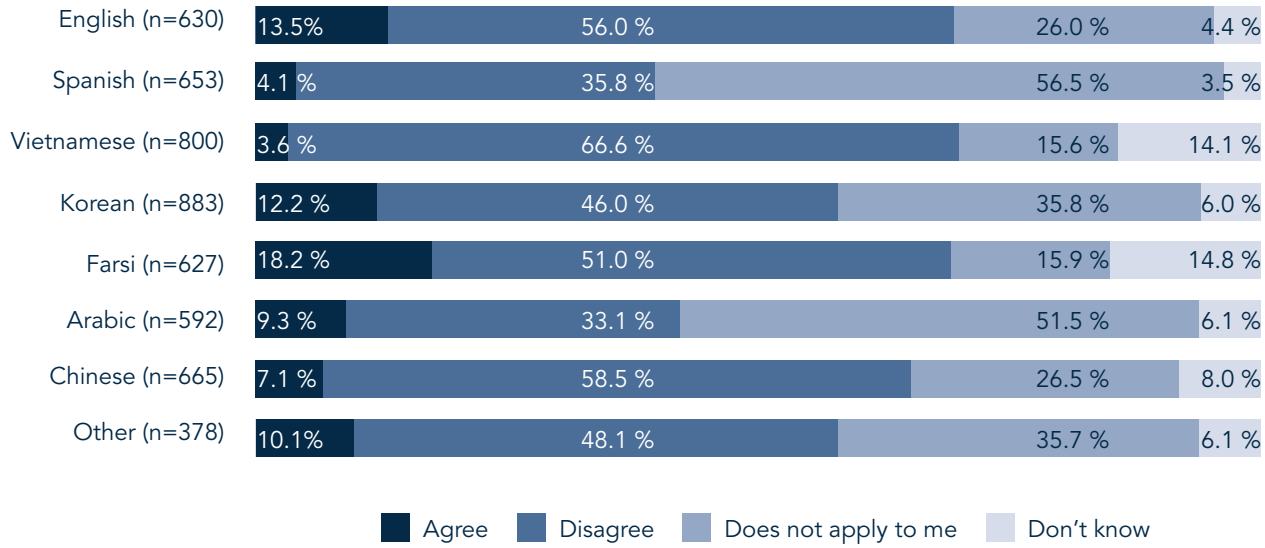
Social isolation negatively impacts the overall health and well-being of some CalOptima member populations. Social isolation is characterized by a lack of social supports and relationships. It occurs for many reasons, including language barriers, immigration status, age, ability and sexual orientation. In focus groups, members described how feelings of being disconnected from the community can lead to depression, lack of follow-up with health care or service providers, and negative health behaviors. In the survey, 10 percent of all respondents indicated that they felt lonely or isolated. Yet there were higher rates among certain populations, with loneliness and isolation affecting more speakers of English (13.5 percent), Korean (12.2 percent) and Farsi (18.2 percent) (Exhibit 4).

Exhibit 4: Percent of those who reported feeling lonely or isolated by language



Environmental factors also contribute to social isolation and other negative health behaviors, such as lack of physical activity. Focus group participants discussed feeling unsafe in their neighborhoods, which caused them to stay inside or to avoid nearby parks and/or other common spaces.

In addition, lack of affordable housing was a major concern to MHNA respondents, and it resulted in living in overcrowded households, neighborhoods with high crime rates, areas with poor indoor and outdoor air quality, and in the most extreme cases, homelessness.

Bright Spot: CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health a priority, not a lack of knowledge or concern.

Opportunity: CalOptima has already taken steps to strengthen the safety net for members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand this work would positively impact health outcomes in the long run. CalOptima can ensure that providers and community partners understand the social and economic issues that members face and how to adapt health care services accordingly.

KEY FINDING: MENTAL HEALTH

Lack of knowledge and fear of stigma are key barriers to using mental health services.

About 14 percent of members reported needing mental health services in the past year (Exhibit 5). However, local and national data suggest that the need for mental health services is likely underreported and underrecognized. Among those reporting a need, nearly 25 percent did not see a mental health specialist (Exhibit 6). Members did not seek mental health services for several reasons (Exhibit 7), including not knowing who to call or how to ask for help making an appointment (39.8 percent), not feeling comfortable talking about personal problems (37.5 percent) or concern that someone would find out they had a problem (26.1 percent). These factors, along with data gathered from key stakeholder interviews and focus groups, reflect a fear of stigma associated with seeking mental health services.

Exhibit 5: Percent of members who indicated they needed to see a mental health specialist (n=5,723)

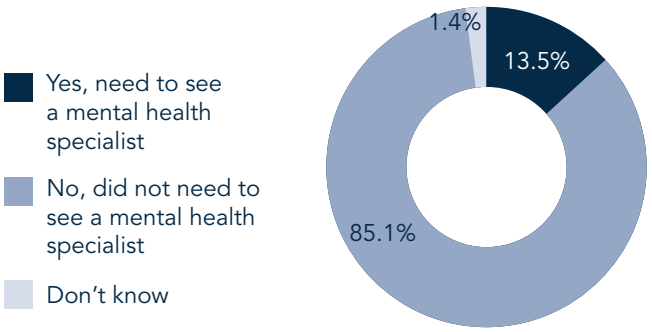
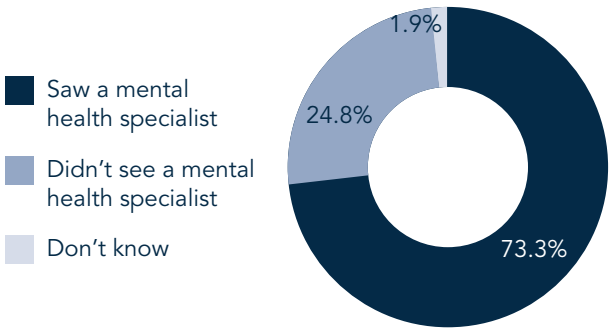
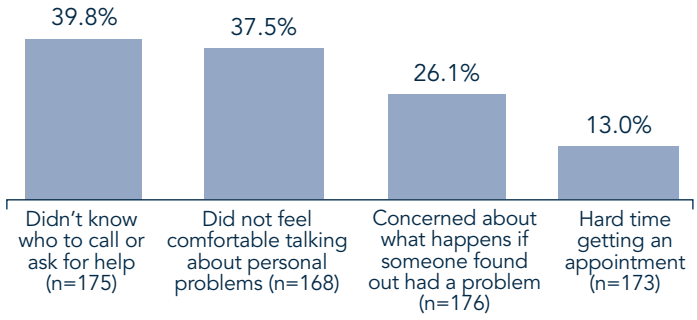


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



Fear of stigma is more prevalent among certain language groups. For example, Chinese-speaking members were more likely to indicate discomfort talking about personal problems and concern about what others might think if they found out about a mental illness than other language groups, followed by Korean-, Vietnamese- and English-speaking members. Conversations with community members and service providers offered cultural context for these findings as many stakeholders described prevalent feelings of shyness, avoidance and shame around discussing mental health issues, let alone seeking care.

Exhibit 7: Reasons why members (who needed to see a mental health specialist but) didn't get services



Bright Spot: CalOptima provides access to mental health services, which meets a clearly established need. Although members needing mental health services do not always connect with providers, many do not do so because of a lack of knowledge, an issue that can be addressed through strengthened connections with existing systems.

Opportunity: Although mental health services are covered by CalOptima, fear of stigma may prevent members from seeking services. This presents an opportunity for CalOptima to continue to provide culturally relevant education around mental health to improve understanding of available services and to address fear of stigma many people face. Community partners with deep knowledge of specific cultural communities are eager to offer support that would increase the use of mental health services.

KEY FINDING: PRIMARY CARE

Most members are connected to primary care, but barriers can make it challenging to receive timely care.

The majority of CalOptima members indicated that they are connected to at least one primary care doctor (82.6 percent), and most go to a doctor's office (69.2 percent) or clinic/health center (18.1 percent) when they need medical attention (Exhibits 8 and 9). However, navigating the health care system can be challenging, and significant barriers make it difficult for people to seek or follow through with care when needed.

Exhibit 8: Percent who report at least one person as their doctor (n=5,749)

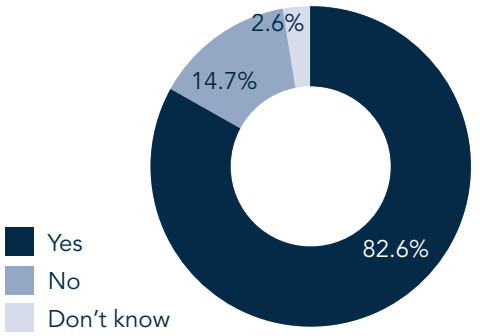
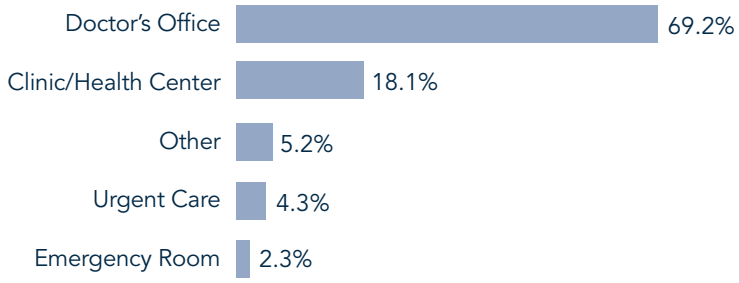


Exhibit 9: Where respondents go to see their doctor (n=5,743)

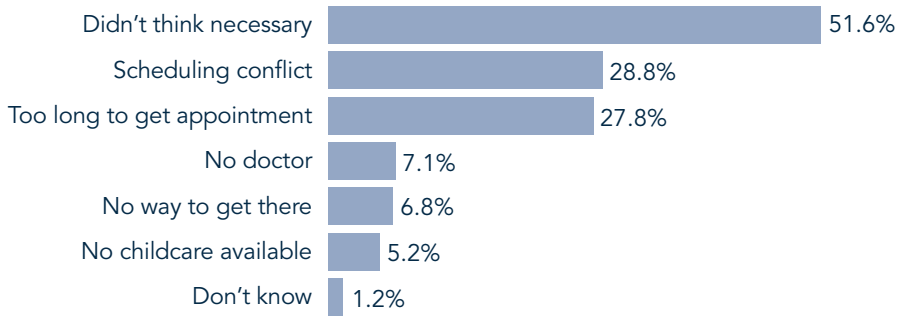


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited hours of operation and inefficiency of public transportation, can make it difficult for people to receive care when needed. When asked why they don't make an appointment to see a doctor, 27.8 percent of CalOptima members indicated that it takes too long to get an appointment while 51.6 percent of members did not think it was necessary to make an appointment (Exhibit 10).

Bright Spot: CalOptima members have access to more than 1,500 primary care providers and 6,200 specialists, as well as 14 different health networks. And staff members are dedicated to continually engaging and educating these providers and networks to ensure they are ready to deliver the care needed by members.

Opportunity: The challenge of maintaining a robust provider network never goes away, and CalOptima must carefully monitor members' access to care. The provider community may be ready to embrace innovations that enhance access, such as extended hours, weekend operations or telemedicine visits, to expand the options for members.

Exhibit 10: Reasons why members don't make an appointment to see doctor (n=4,598)[1]



KEY FINDING: PROVIDER ACCESS

Members are culturally diverse and want providers who both speak their language and understand their culture.

CalOptima members hail from around the globe, reflecting the rich diversity of Orange County's population. In total, 40.3 percent of respondents were born outside of the U.S. and 23.6 percent indicated that they don't speak English well (Exhibits 11 and 12). Among non-English speakers, more than 50 percent were born outside of the United States and many are still acculturating to life in the U.S. This presents challenges when finding a well-paying and fulfilling job, safe and affordable housing, and healthy and familiar food. It also affects the ways members interact with the health care system. In fact, those born outside of the U.S. were significantly less likely to have a doctor and more likely to report feeling lonely or isolated.

Exhibit 11: How well members speak English (n=5,549)

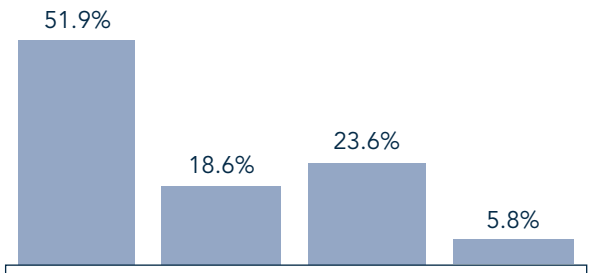
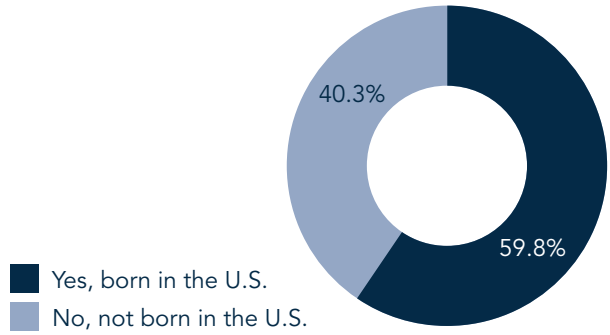


Exhibit 12: Percent of members who were born in the United States (n=5,599)



Further, they report having to adapt to new ways of receiving medical care. Some focus group participants shared that they did not understand why they must wait so long to see a doctor, as it is not this way in their country of origin. Others shared that cultural beliefs and practices made them uncomfortable and often unwilling to see a physician of the opposite gender. In addition, members and key stakeholders indicated that it can be challenging to seek medical care from providers who do not speak members' preferred language, which leads to issues with communication and comfort level. Although many stakeholders highlighted the availability of translation or interpretation services, such services do not always meet members' needs, especially when limited by short appointment times and when sharing sensitive information.

Bright Spot: CalOptima provides services and resources to members in seven languages[2] and can connect members to translation and interpretation services in any language when needed. Members appreciate that CalOptima recognizes the importance of providing care in familiar languages, and they also highly value providers who are sensitive to the cultural norms and practices of their homeland.

Opportunity: CalOptima has an opportunity to build its existing resources and deepen cultural competence of providers and services. CalOptima can engage partners in culturally focused community-based organizations to tailor and implement trainings for providers around specific populations. Trainings can build language and sensitivity skills and increase knowledge in areas such as ethnopharmacology (variations in medication responses in diverse ethnic populations). This can strengthen the workforce and improve member/provider interactions overall.

KEY FINDING: DENTAL CARE

Many members are not accessing dental care and are often unsure about what dental services are covered.

The gap in dental health care is striking and pronounced; 38.2 percent of members indicated they had not seen a dentist within the past 12 months (Exhibit 13). Among those individuals, 41 percent cited cost as the main reason they did not see a dentist (Exhibit 14). Members expressed confusion about dental care benefits available to them via Medi-Cal/Denti-Cal, and they said they would be more likely to seek out a dentist if they knew some of their visits were covered.

Bright Spot: Members in all CalOptima programs are eligible for routine dental care through Denti-Cal, and members in OneCare and OneCare Connect have access to supplemental dental care as well. Better yet, for 2018, California restored additional Denti-Cal benefits, expanding the covered services even further. The challenge is ensuring that members know about these benefits and then actually obtain the services.

Opportunity: To boost the number of members receiving dental care, CalOptima will have to first raise awareness about the availability of services and correct misperceptions that dental care comes at a cost. Further, to remove barriers to care and expand access, the community may embrace the use of alternative providers, such as mobile dental clinics, or the option of co-located dental and medical services.

Exhibit 13: When members last saw a dentist (n=5,685)

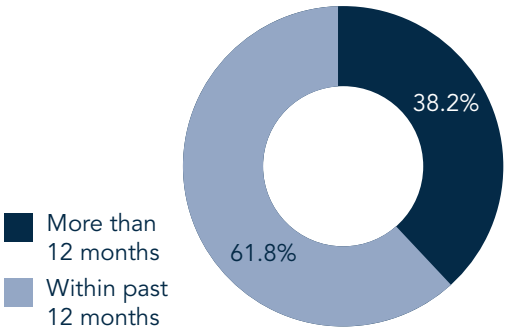
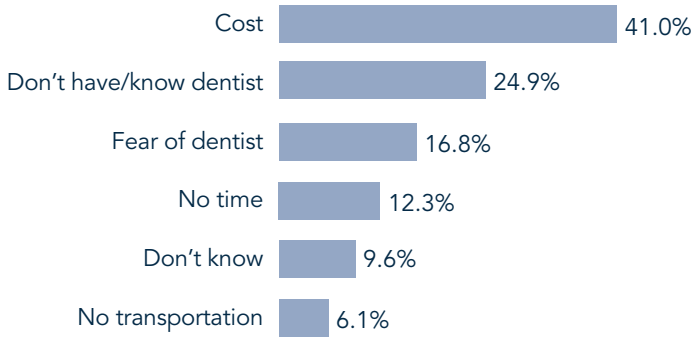


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3] [4]



Endnotes

[1] Members could choose multiple answers; thus, the total does not equal 100 percent.

[2] CalOptima provides bilingual staff, interpreter services, health education and enrollment materials in seven languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.

[3] Members could choose multiple answers; thus, the total does not equal 100 percent.

[4] Only reported those who have not seen a dentist within the past 12 months.

January 2018

CalOptima Member Survey Analysis:

Unweighted Estimates by Language, Region, and Age

DRAFT

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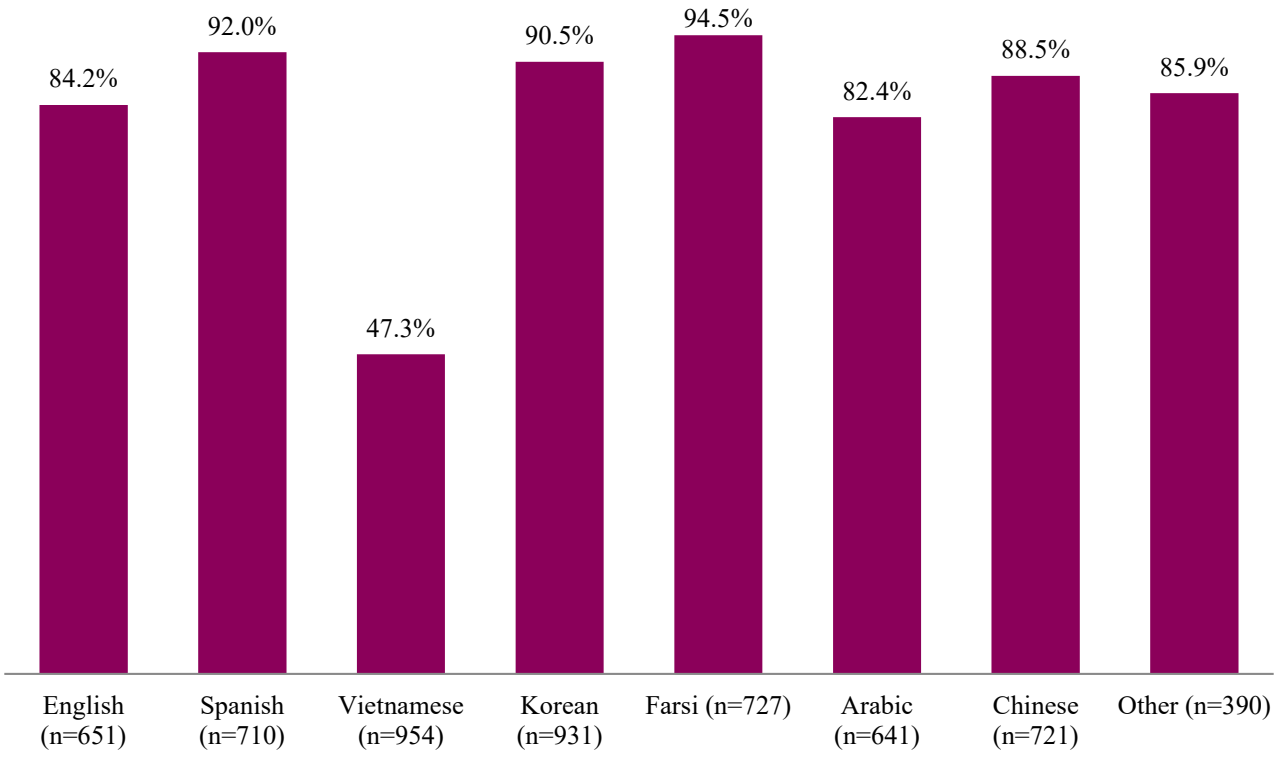
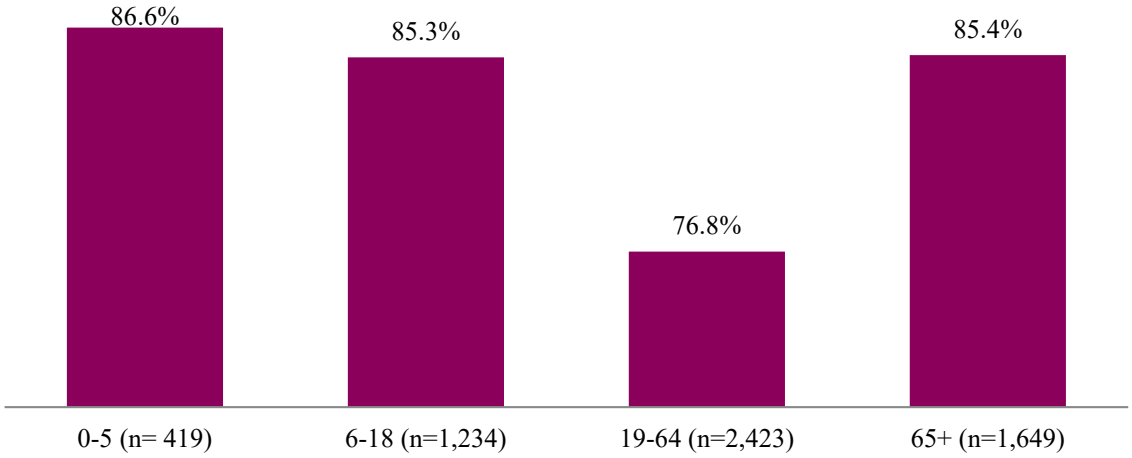
Navigating the Healthcare System

Exhibit 1. Percent who report at least one person as their doctor[1]

CalOptima language:



Age Group:



[1] An issue was identified with the Vietnamese translation of this question. Therefore, results likely misrepresent percentage of Vietnamese members who have a doctor.

Region:

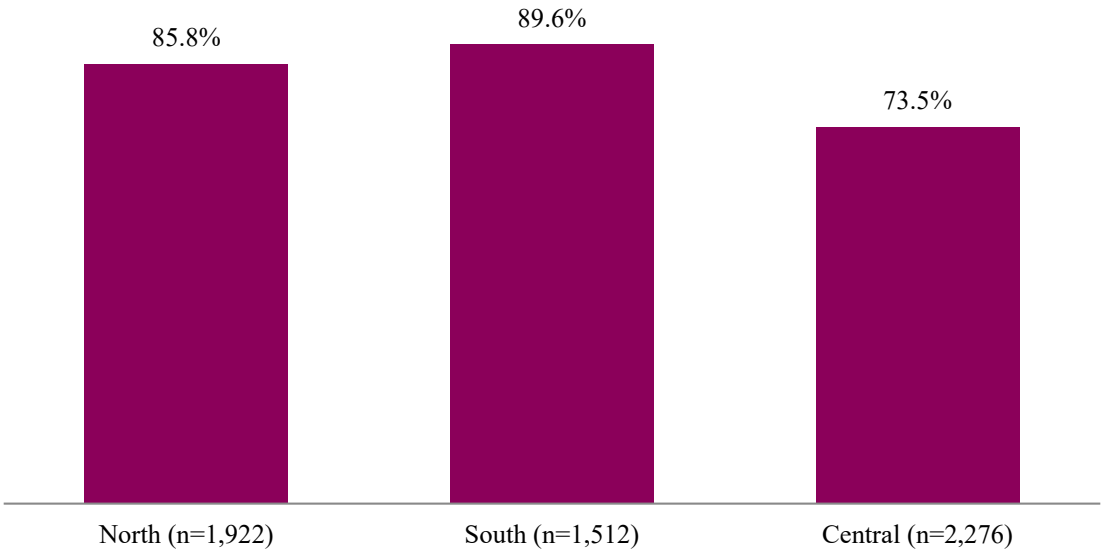


Exhibit 2. Where respondents go to see their doctor

CalOptima language:

CalOptima Language	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
English	71.8%	11.9%	2.0%	6.6%	0.5%	6.4%	0.8%	653
Spanish	59.7%	32.3%	3.4%	1.0%	0.3%	3.1%	0.1%	699
Vietnamese	86.3%	12.0%	0.1%	0.2%	0.0%	1.0%	0.3%	965
Korean	87.8%	4.3%	0.9%	1.1%	0.7%	4.1%	1.2%	938
Farsi	84.0%	6.5%	3.0%	0.8%	0.1%	5.0%	0.5%	737
Arabic	65.3%	15.8%	4.6%	5.4%	0.3%	8.0%	0.5%	625
Chinese	77.2%	11.4%	0.3%	0.8%	0.4%	6.6%	3.3%	727
Other	72.2%	12.6%	1.5%	3.0%	0.0%	9.6%	1.0%	396

Age Category:

CalOptima Age Category	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	68.4%	19.1%	1.9%	2.7%	0.2%	7.2%	0.5%	414
6-18 (Children)	73.0%	16.5%	1.6%	3.0%	0.4%	4.4%	1.0%	1,224
19-64 (Adults/MCE)	73.1%	14.2%	2.6%	2.7%	0.5%	5.5%	1.4%	2,425
65+ (Older Adults)	87.5%	6.8%	0.8%	0.4%	0.1%	4.1%	0.4%	1,677

Region:

CalOptima Region	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
North	74.4%	13.8%	1.7%	3.4%	0.4%	5.4%	1.0%	1,920
South	80.4%	7.9%	2.0%	1.4%	0.5%	6.4%	1.4%	1,521
Central	76.8%	15.5%	1.8%	1.4%	0.2%	3.6%	0.6%	2,284

Exhibit 3. Reasons why members go somewhere other than their doctor when they need medical attention

CalOptima language:

CalOptima Language	I don't have a doctor	It is easier for me to get to the emergency room or urgent care than my doctor's office	It's hard to get an appointment with my doctor	Other	Don't know	n
	%	%	%	%	%	
English	7.4%	26.5%	21.4%	40.7%	4.0%	570
Spanish	7.5%	22.2%	20.1%	37.9%	12.4%	523
Vietnamese	3.1%	31.8%	16.8%	46.2%	2.1%	584
Korean	11.5%	22.7%	27.8%	37.6%	0.4%	687
Farsi	3.1%	15.4%	22.7%	58.8%	0.0%	422
Arabic	5.2%	40.6%	25.5%	28.0%	0.7%	554
Chinese	9.1%	26.8%	14.6%	47.9%	1.6%	549
Other	6.0%	24.9%	16.7%	50.8%	1.6%	317

Age Category:

Age Category	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
0-5 (Children)	4.5%	34.4%	25.4%	29.3%	6.5%	355
6-18 (Children)	5.2%	27.7%	24.0%	36.2%	6.9%	986
19-64 (Adults/MCE)	9.2%	26.0%	23.7%	39.9%	1.3%	1,789
65+ (Older Adults)	4.5%	34.4%	25.4%	29.3%	6.5%	1,076

Region:

Region	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
North	7.4%	27.1%	25.2%	38.4%	1.9%	1,501
South	6.7%	23.1%	20.5%	47.2%	2.5%	1,052
Central	6.3%	28.9%	17.6%	43.2%	4.0%	1,639

Exhibit 4. When do members make an appointment to see doctor[2]

CalOptima Language:

CalOptima Language	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
English	75.8%	77.2%	51.8%	1.1%	4.2%	650
Spanish	77.7%	76.2%	36.9%	0.8%	4.5%	713
Vietnamese	76.0%	74.7%	39.7%	0.1%	1.7%	973
Korean	81.3%	75.2%	47.4%	0.4%	0.6%	938
Farsi	87.4%	80.0%	65.1%	1.8%	3.7%	736
Arabic	82.5%	40.4%	30.9%	0.5%	1.4%	644
Chinese	80.3%	73.6%	48.6%	1.5%	1.2%	727
Other	70.1%	82.0%	51.1%	1.5%	4.6%	395

Age Category:

Age Category	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
0-5 (Children)	86.4%	76.9%	41.9%	0.7%	1.2%	420
6-18 (Children)	81.8%	73.2%	39.9%	0.5%	2.2%	1,236
19-64 (Adults/MCE)	78.0%	67.9%	47.3%	1.1%	2.3%	2,433
65+ (Older Adults)	77.8%	77.4%	50.0%	0.9%	3.4%	1,687

[2] **Members were allowed to choose multiple answers; thus, the total does not equal 100%.**

Region:

Region	When Sick	Check-Up	Specialist Needed	Don't Know	Other	n
	%	%	%	%	%	
North	78.2%	70.5%	43.6%	0.9%	2.3%	1,938
South	83.3%	75.9%	55.9%	1.3%	2.8%	1,527
Central	77.7%	72.0%	41.8%	0.5%	2.5%	2,296

Exhibit 5. Reasons why members don't make an appointment to see doctor[3]

CalOptima language:

CalOptima Language	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
English	7.8%	6.7%	28.0%	27.6%	5.2%	54.0%	1.8%	554
Spanish	6.3%	6.5%	20.8%	27.4%	5.2%	53.2%	0.8%	504
Vietnamese	2.3.%	7.0%	50.9%	24.8%	4.1%	42.8%	0.0%	725
Korean	11.7%	4.1%	48.4%	39.7%	3.8%	31.5%	0.0%	677
Farsi	5.7%	19.5%	24.9%	45.1%	6.9%	33.3%	0.0%	406
Arabic	2.7%	7.0%	28.2%	42.6%	2.1%	37.1%	0.0%	561
Chinese	7.2%	9.6%	29.8%	24.8%	2.2%	51.0%	0.9%	541
Other	4.1%	8.8%	25.0%	29.1%	1.7%	56.8%	0.0%	296

[3] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Age Category:

Age Category	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	4.6%	6.5%	32.8%	35.9%	10.5%	43.7%	0.0%	323
6-18 (Children)	4.8%	4.5%	38.2%	32.8%	3.9%	43.4%	0.1%	990
19-64 (Adults /MCE)	7.8%	7.4%	36.3%	34.5%	4.2%	39.5%	0.8%	1,933
65+ (Older Adults)	4.5%	13.3%	26.1%	26.9%	1.3%	53.2%	0.3%	1,018

Region:

Region	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%			
North	7.6%	7.7%	36.3%	35.0%	3.3%	40.5%	0.3%	1,521
South	6.3%	10.5%	27.5%	35.8%	4.8%	45.7%	0.6%	1,019
Central	4.6%	6.9%	35.9%	28.1%	4.0%	46.1%	0.5%	1,712

Exhibit 6. When do members make an appointment to see a specialist[4]

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
English	76.0%	26.5%	63.5%	638
Spanish	71.9%	30.5%	60.7%	679
Vietnamese	70.3%	24.4%	56.7%	949
Korean	69.1%	27.1%	45.2%	877
Farsi	78.6%	31.4%	55.7%	688
Arabic	68.9%	16.3%	42.5%	631
Chinese	66.0%	35.6%	45.4%	694
Other	79.2%	26.8%	59.9%	384

Age Category:

Age Category	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
0-5 (Children)	71.1%	28.4%	53.8%	394
6-18 (Children)	67.7%	25.7%	52.6%	1,172
19-64 (Adults/MCE)	71.5%	25.2%	54.5%	2,328
65+ (Older Adults)	75.7%	31.3%	51.7%	1,646

[4] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Region:

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
North	69.3%	27.7%	50.6%	1,857
South	74.3%	28.3%	52.9%	1,453
Central	72.6%	26.6%	55.5%	2,216

Exhibit 7. Reasons why members don't make an appointment to see specialist[5]

CalOptima Language:

CalOptima Language	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
English	19.5%	8.0%	20.4%	27.0%	41.1%	548
Spanish	7.9%	5.5%	12.0%	20.2%	46.4%	560
Vietnamese	11.3%	9.3%	37.8%	30.7%	33.4%	724
Korean	14.2%	12.5%	32.6%	41.5%	27.6%	696
Farsi	13.9%	14.3%	15.2%	37.6%	24.5%	474
Arabic	9.9%	6.9%	21.5%	47.1%	25.6%	577
Chinese	11.9%	14.6%	17.6%	25.4%	42.6%	556
Other	15.6%	12.6%	16.5%	27.2%	39.2%	334

Age Category:

Age Category	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
0-5 (Children)	10.8%	8.1%	22.8%	33.5%	41.0%	334
6-18 (Children)	12.1%	7.9%	27.2%	32.1%	35.9%	1,019
19-64 (Adults/MCE)	13.7%	9.8%	24.9%	35.5%	31.6%	1,953
65+ (Older Adults)	12.6%	13.8%	16.3%	27.6%	37.0%	1,163

[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Region:

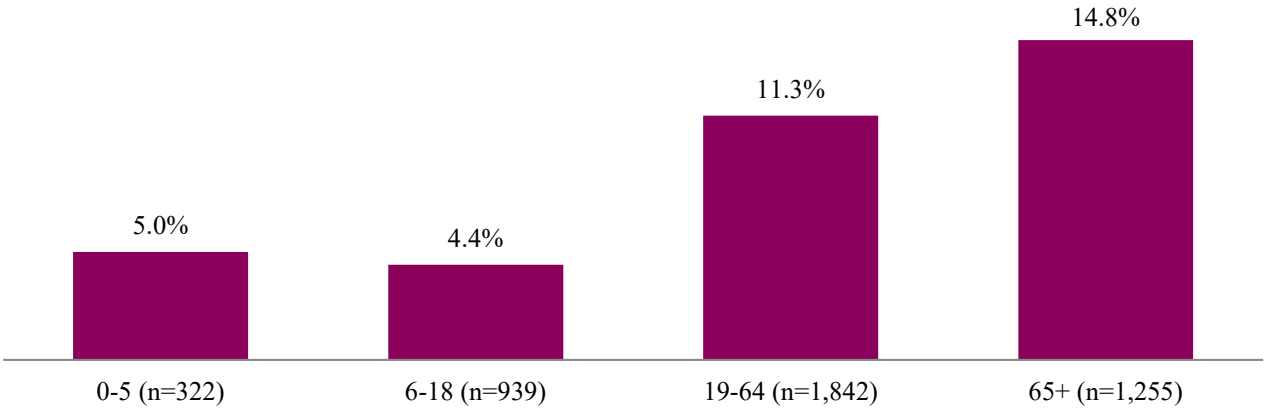
Region	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
North	14.0%	11.3%	24.8%	35.9%	31.1%	1,567
South	13..6%	11.3%	17.5%	33.6%	35.9%	1,097
Central	11.4%	8.8%	24.9%	28.9%	37.2%	1,792

Exhibit 8. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor

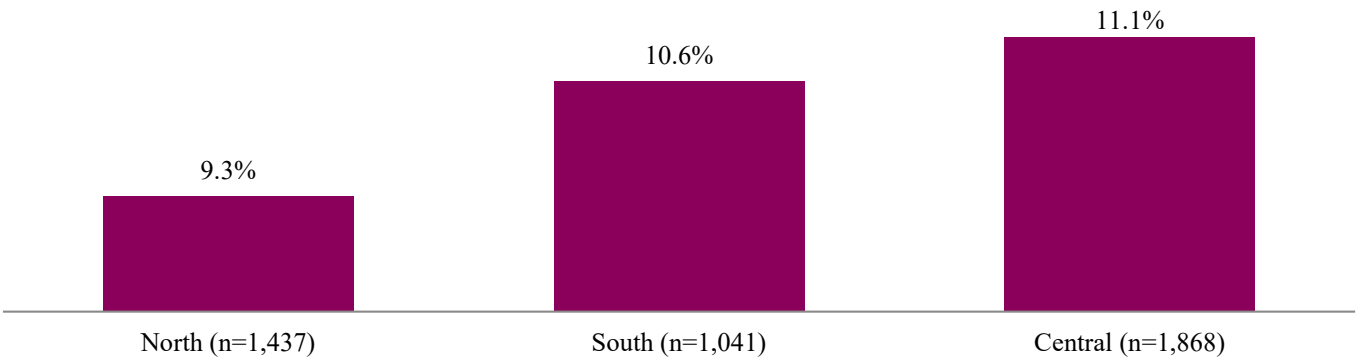
CalOptima language:



Age Category:



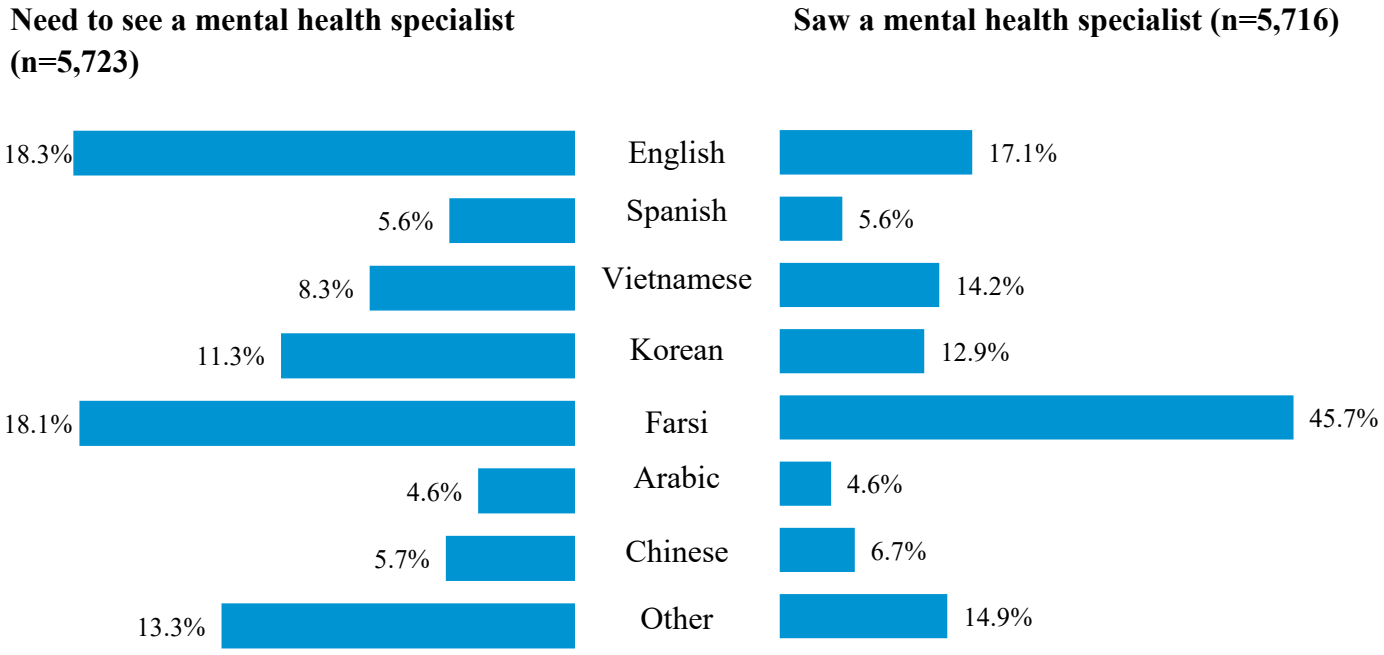
Region:



Social and Emotional Well-Being

Exhibit 9. Members who needed to see compared to those who saw a mental health specialist in the last 12 months[6]

CalOptima Language:

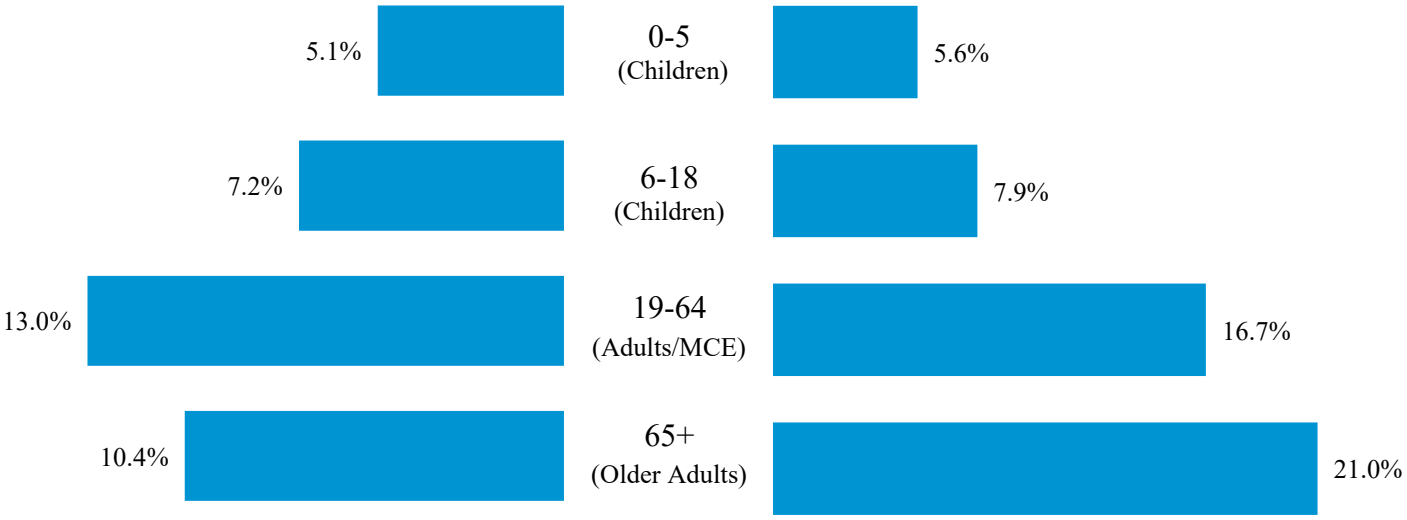


[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

Age Category:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)



Region:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)

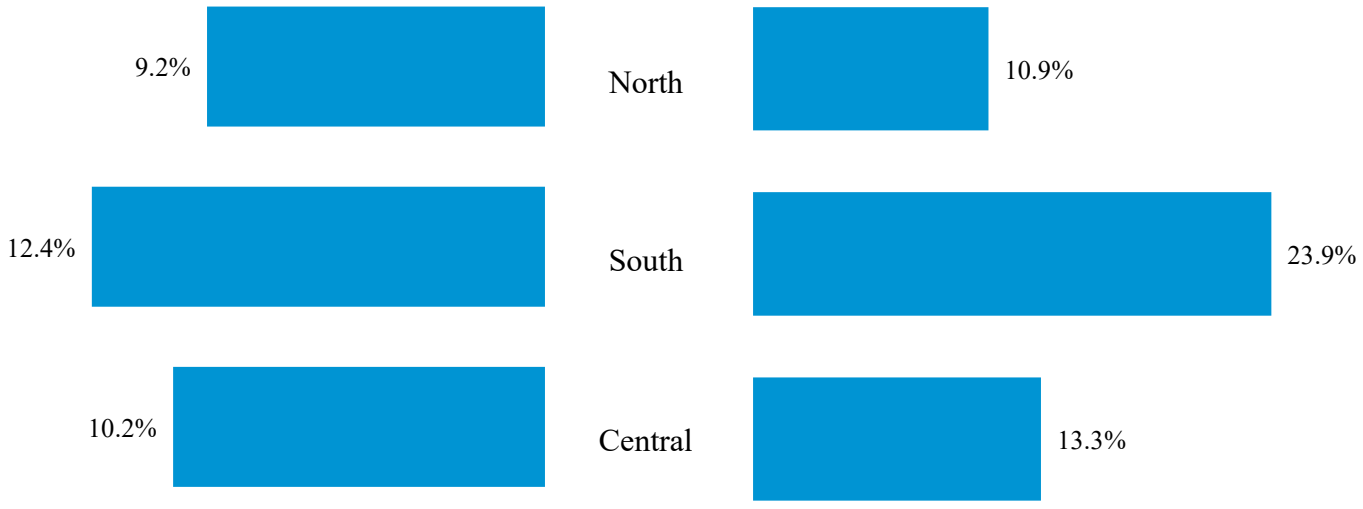
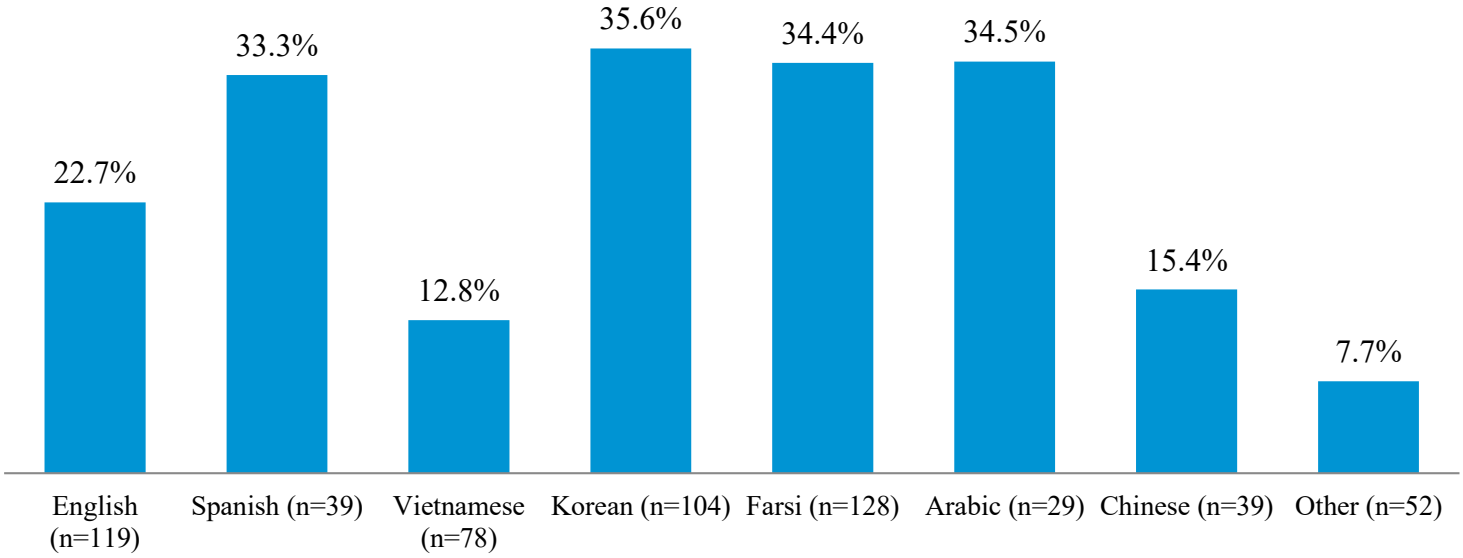
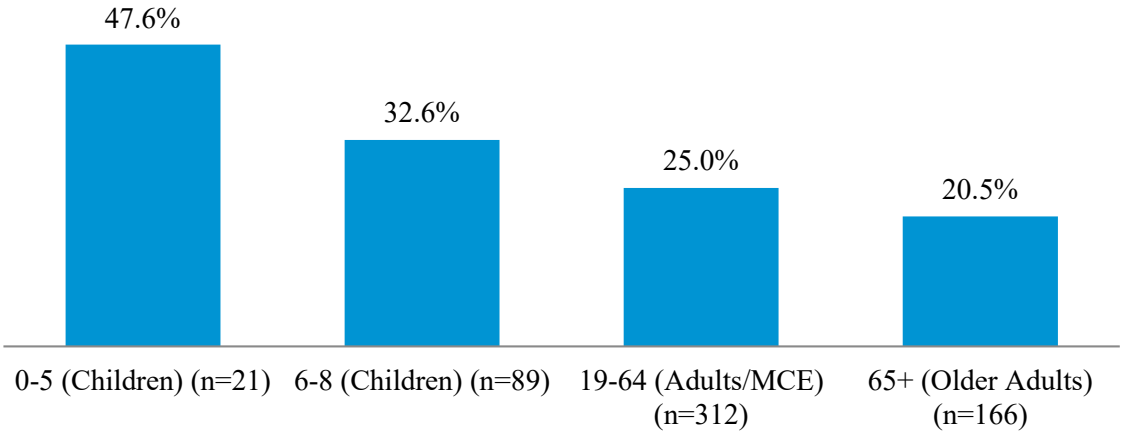


Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist

CalOptima Language:



Age Category:



Region:

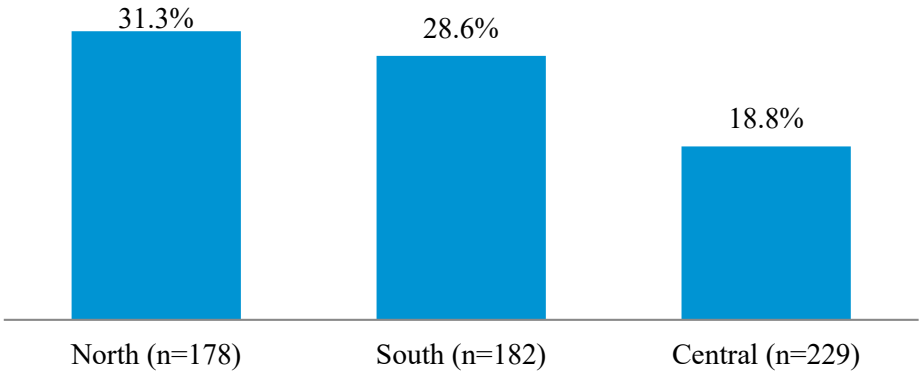
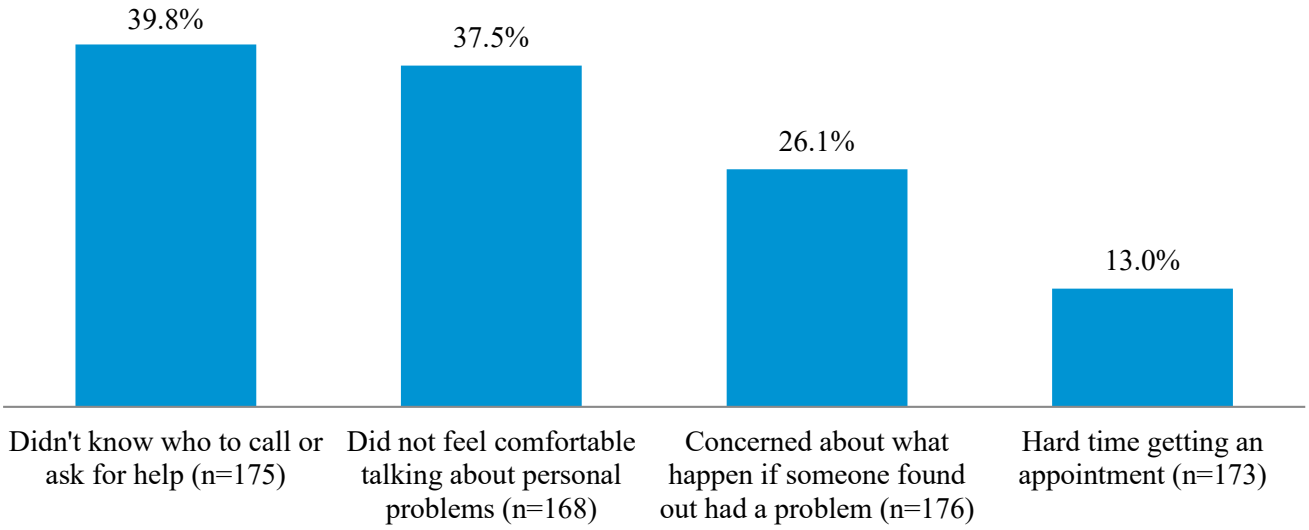


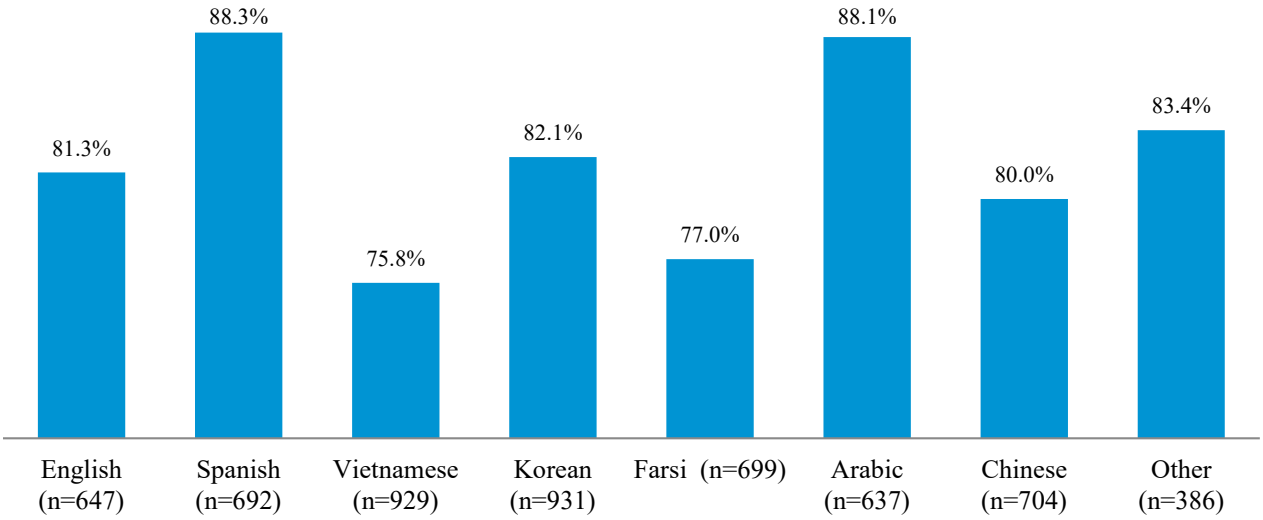
Exhibit 11. Reasons why members didn't see mental health specialist[7]



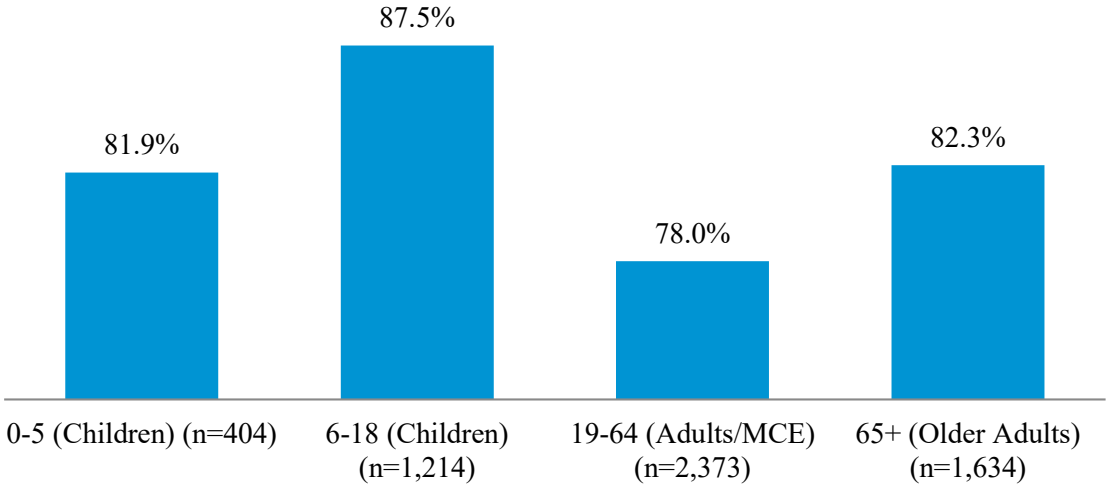
[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

Exhibit 12. Percent of members who can share their worries with family members

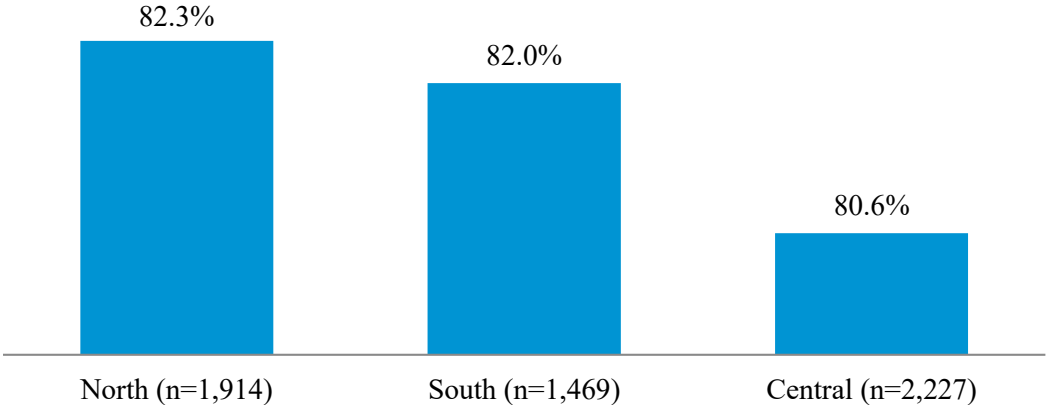
CalOptima language:



Age Category:



Region:

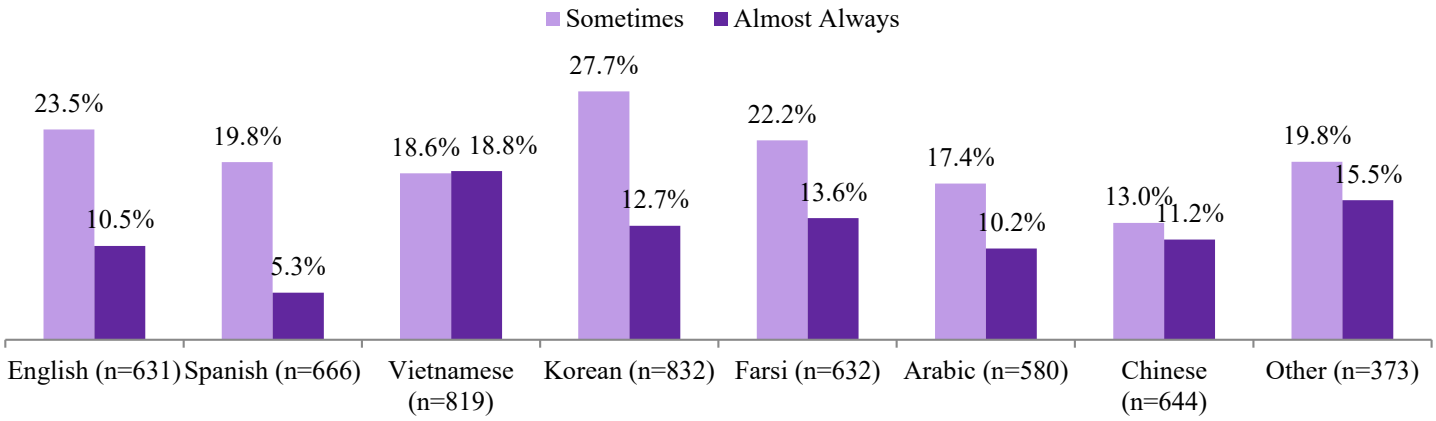


Social Determinants of Health

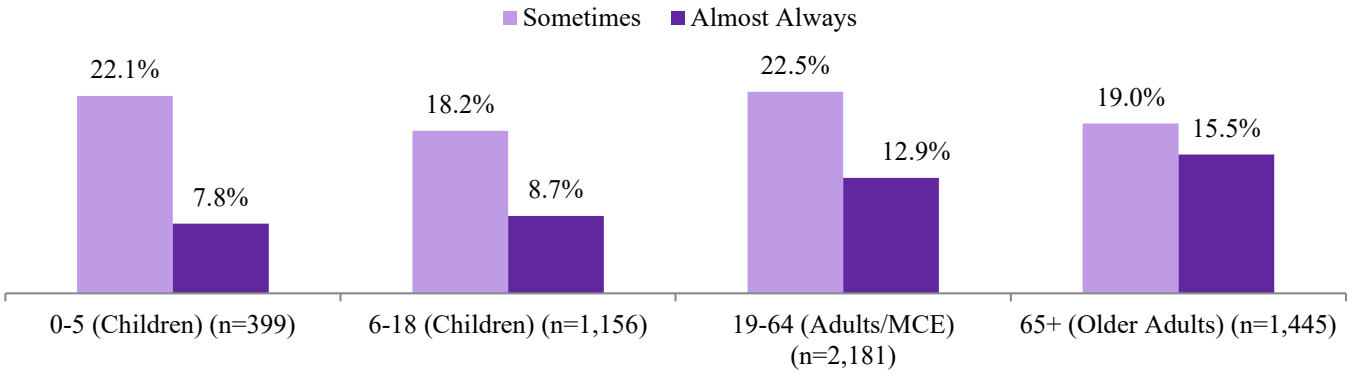
Exhibit 13. Needed help with the following in the past 6 months:

Food for anyone in your household:

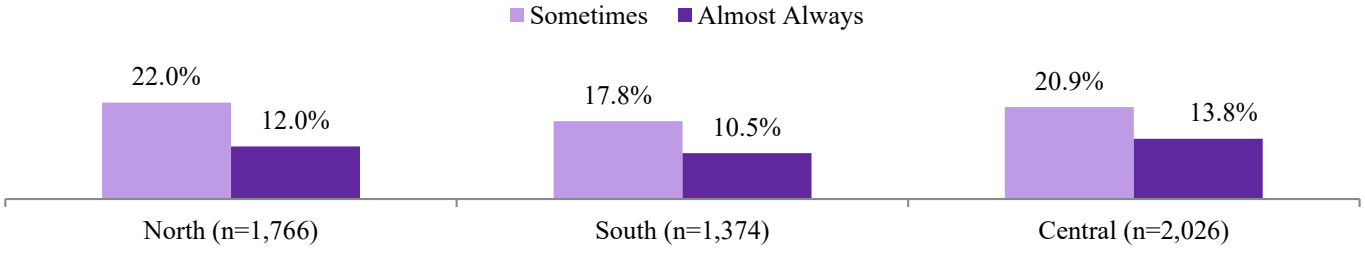
CalOptima language:



Age Category:

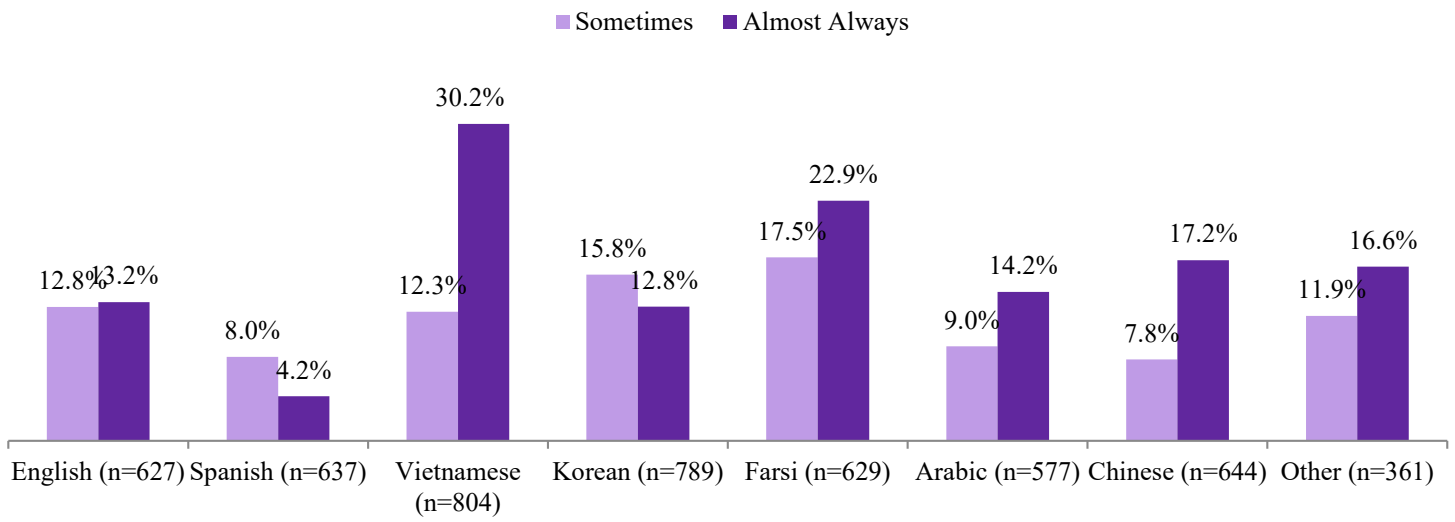


Region:

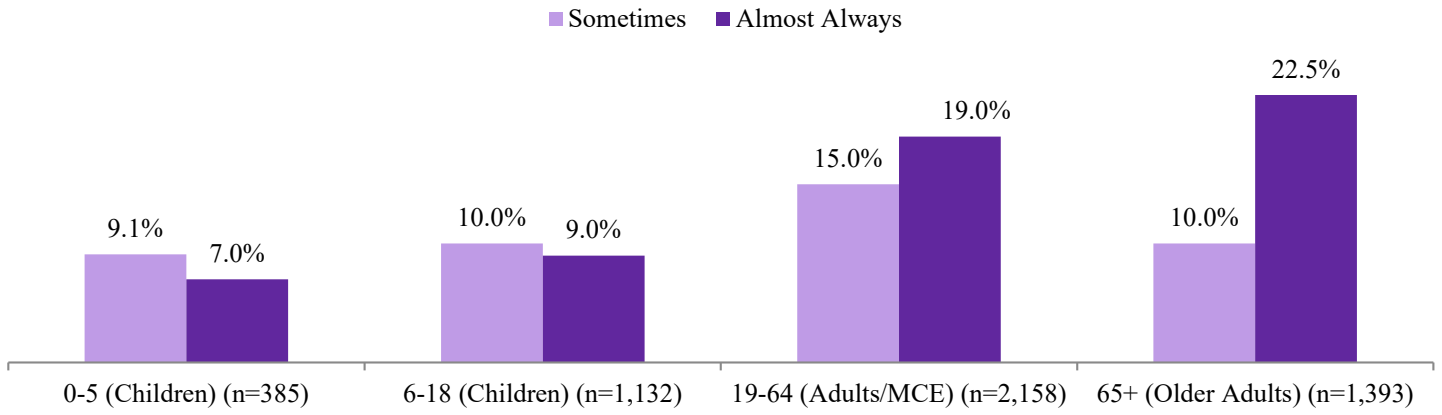


Housing:

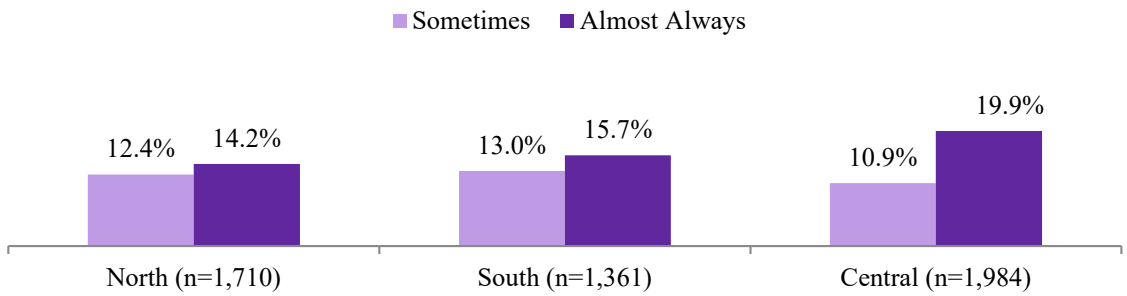
CalOptima language:



Age Category:

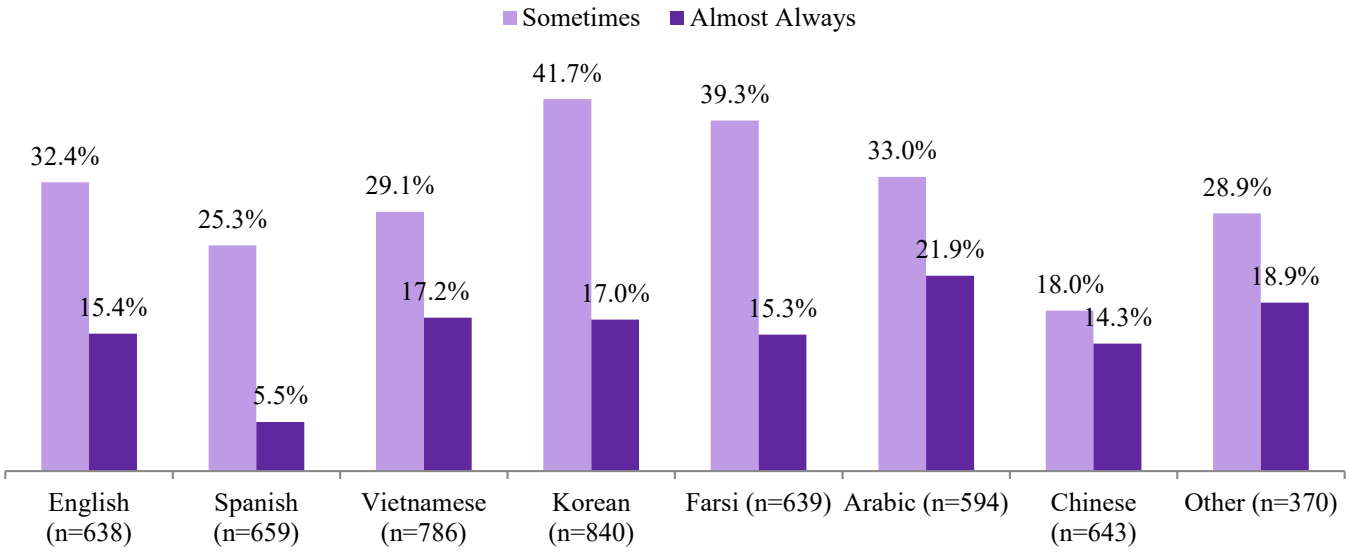


Region:

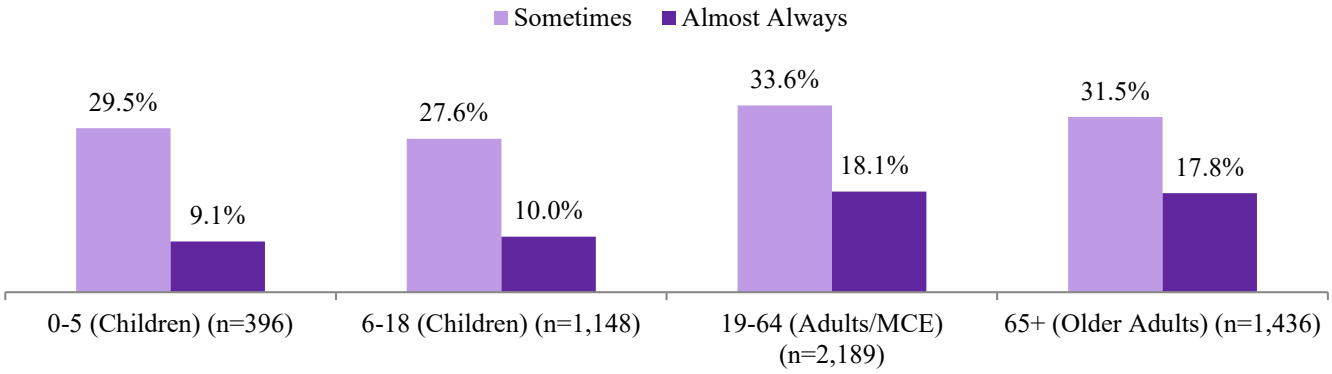


Money to buy things need:

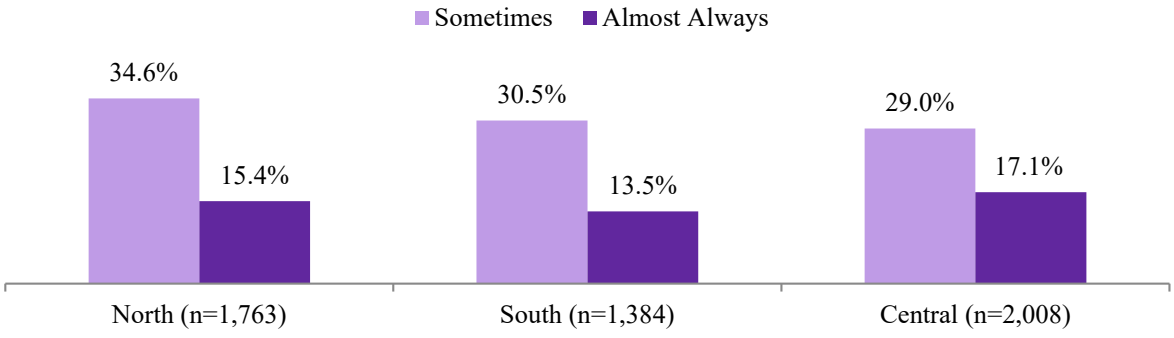
CalOptima language:



Age Category:

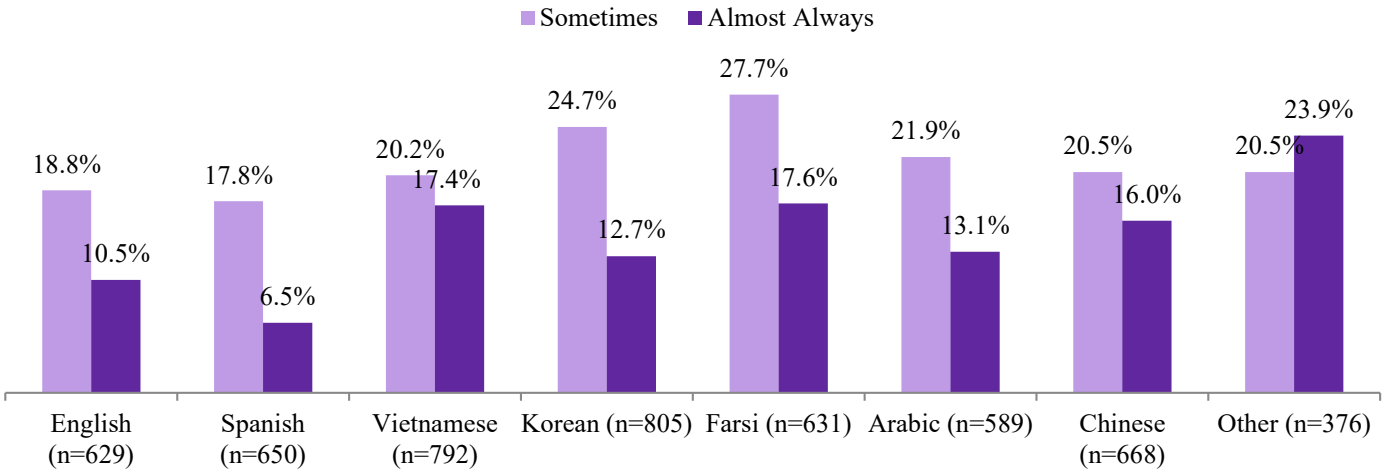


Region:

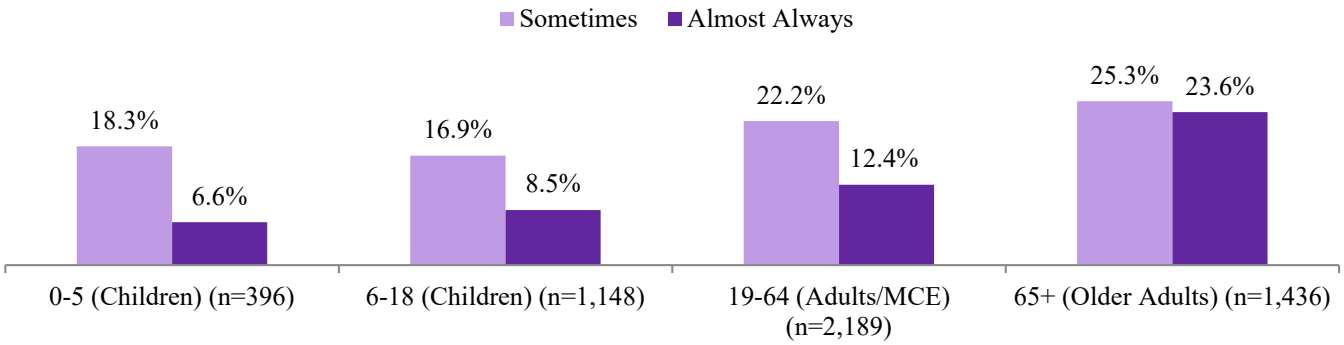


Transportation:

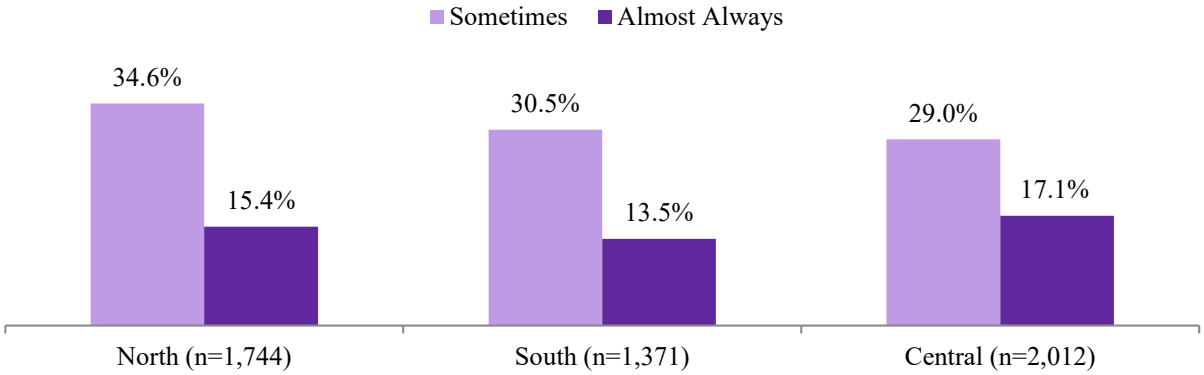
CalOptima language:



Age Category:

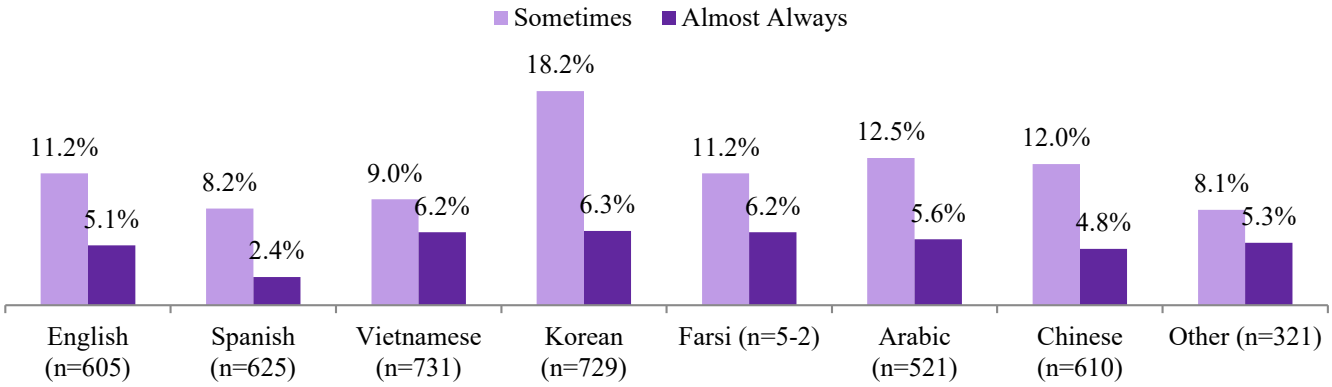


Region:

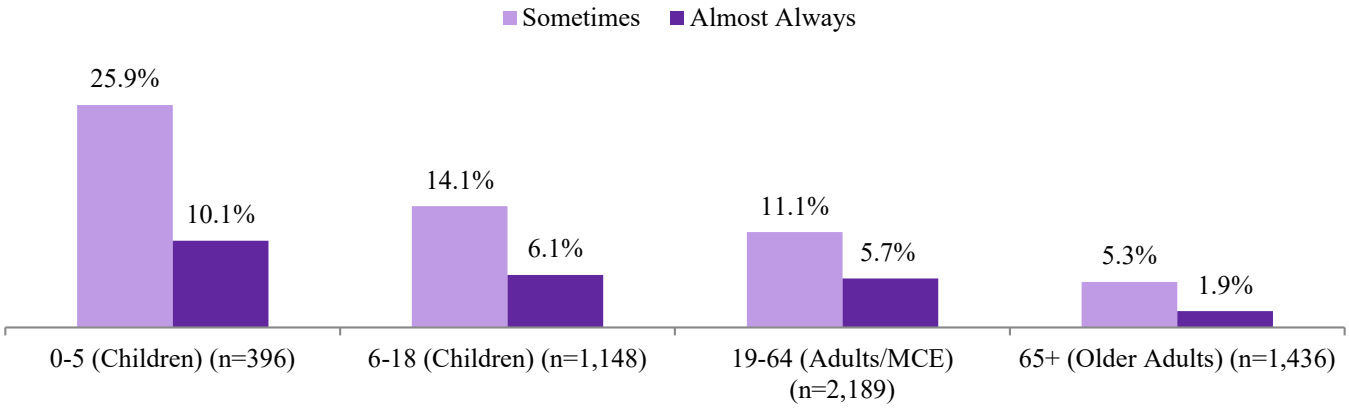


Child care:

CalOptima language:



Age Category:



Region:

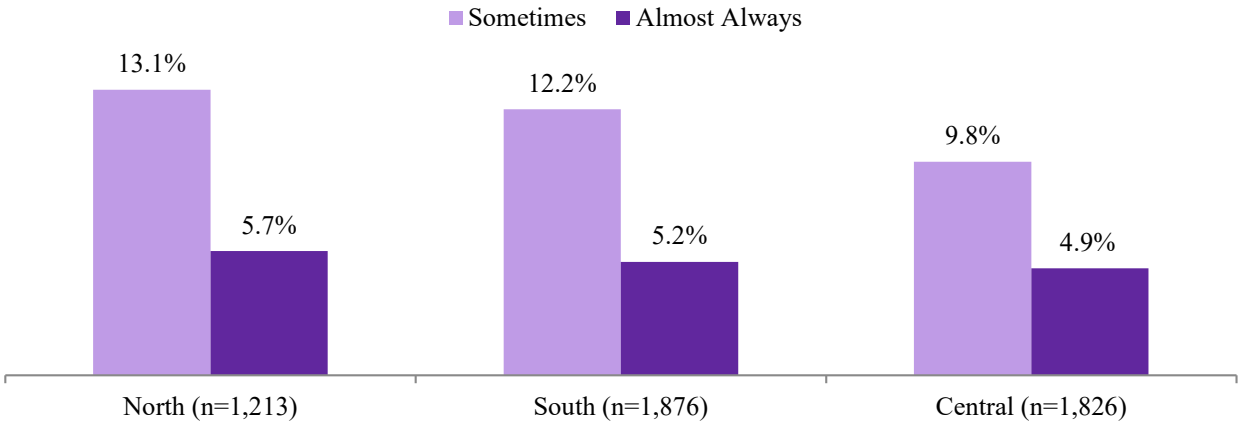
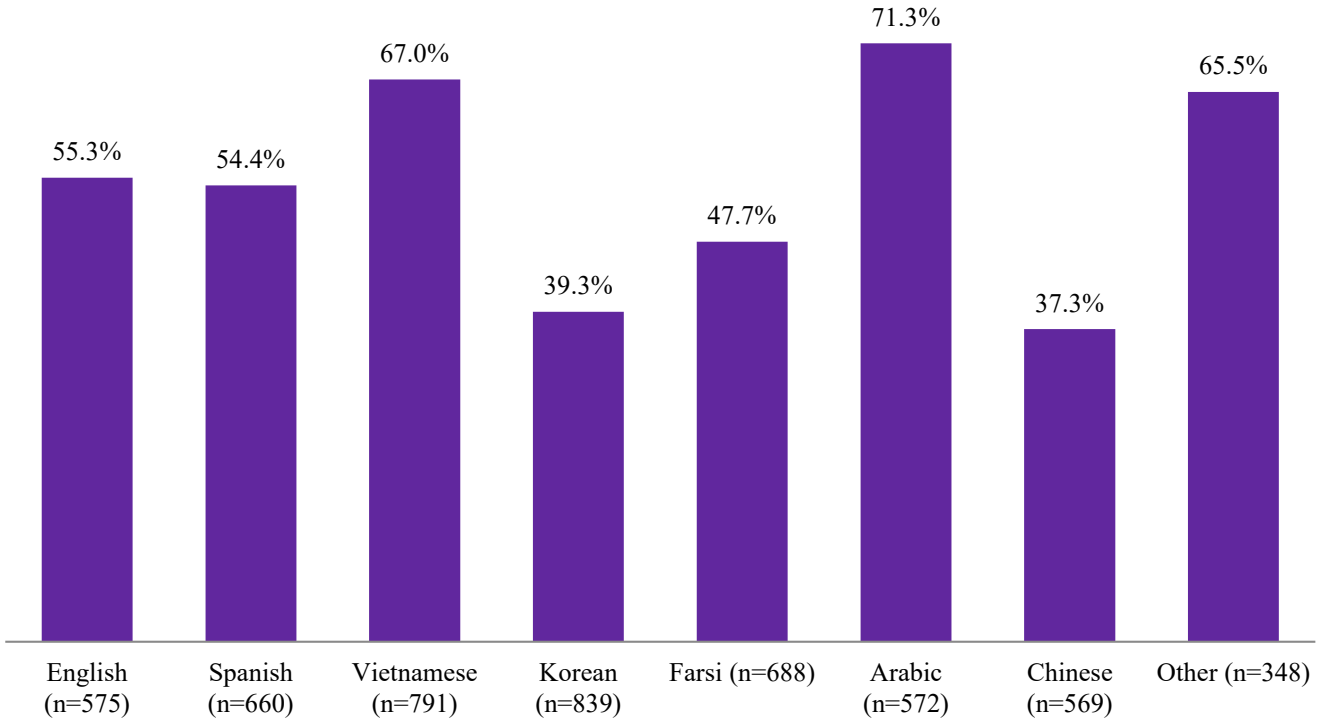


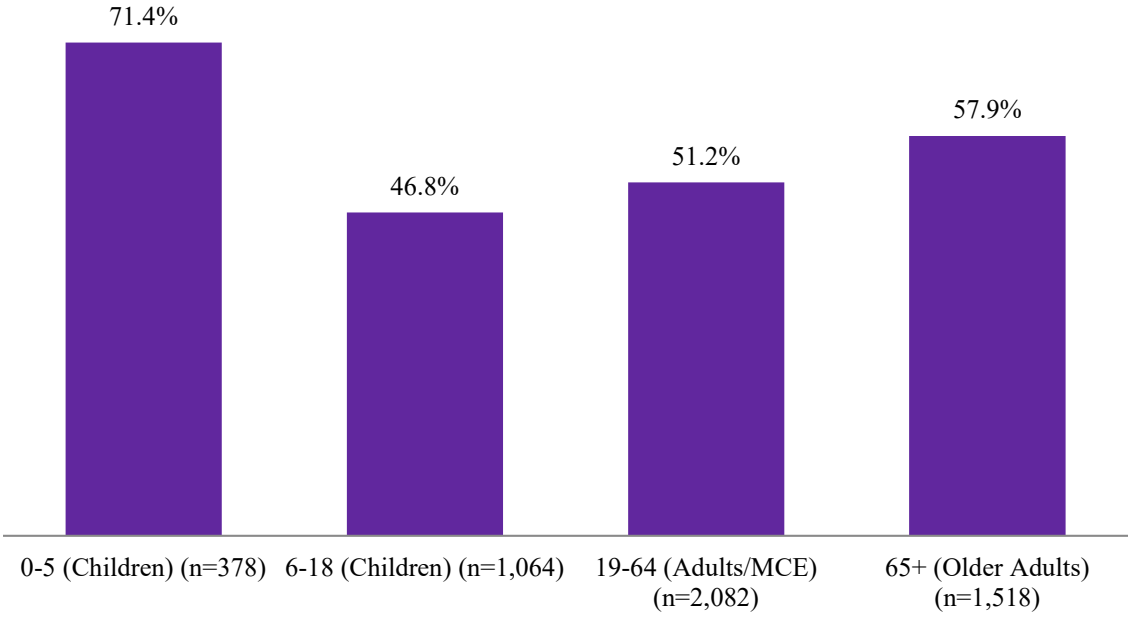
Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

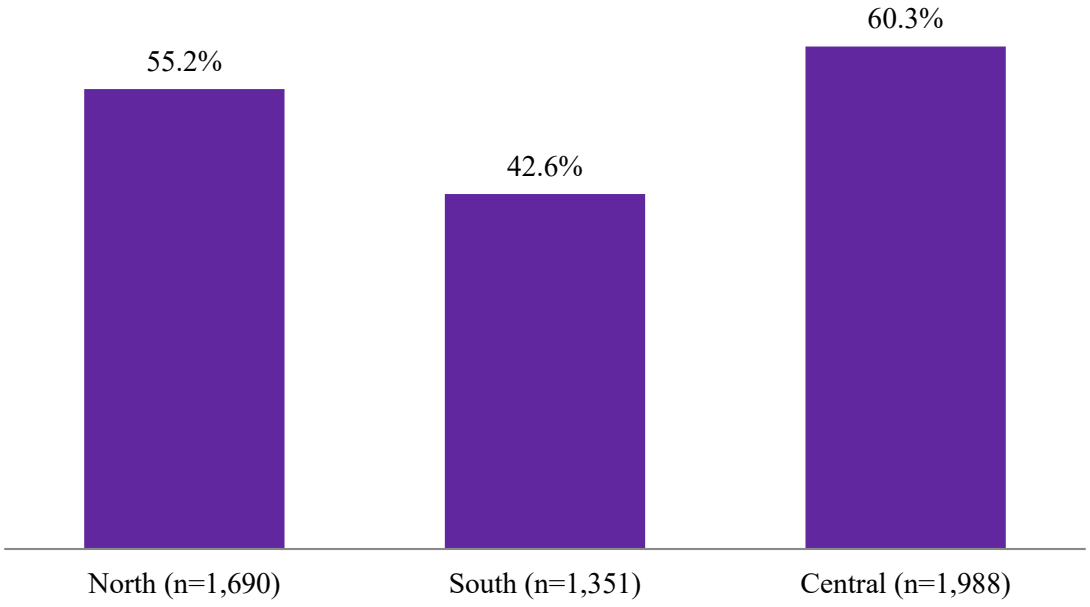
CalOptima language:



Age Category:



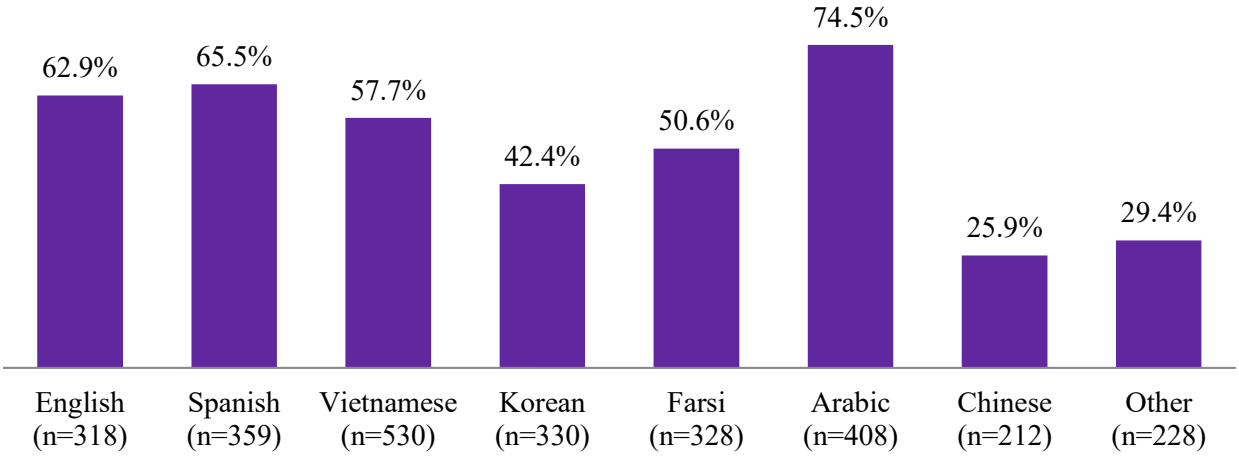
Region:



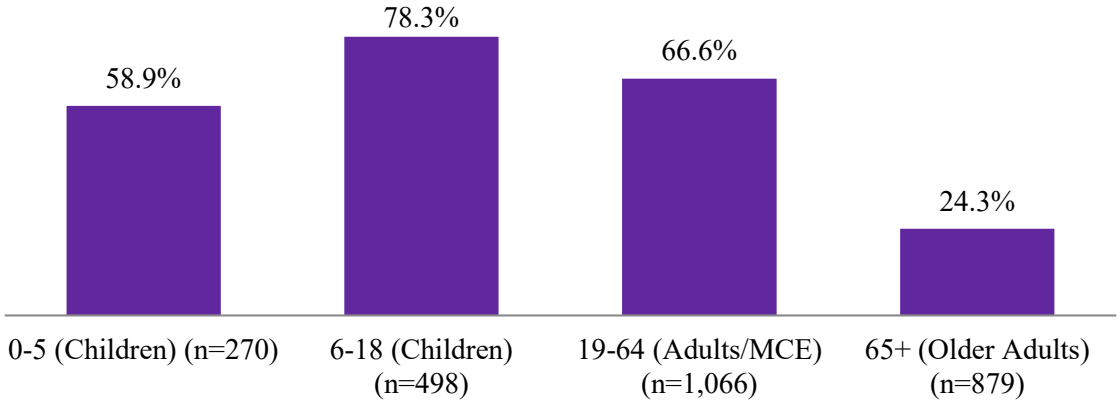
Type of public benefits that members receive[8]:

Receive CalFresh as a public benefit:

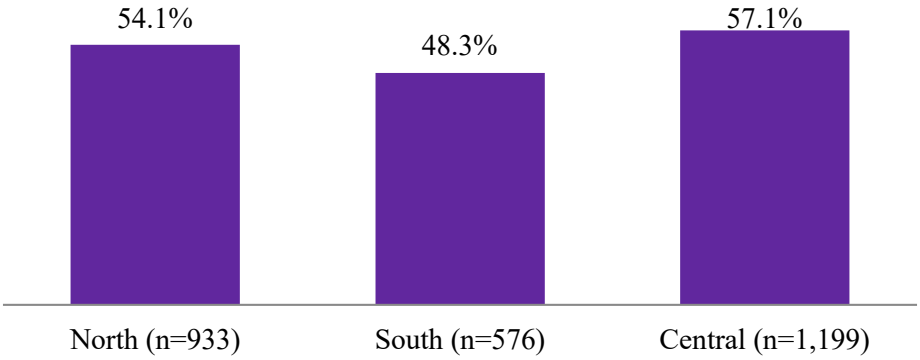
CalOptima language:



Age Category:



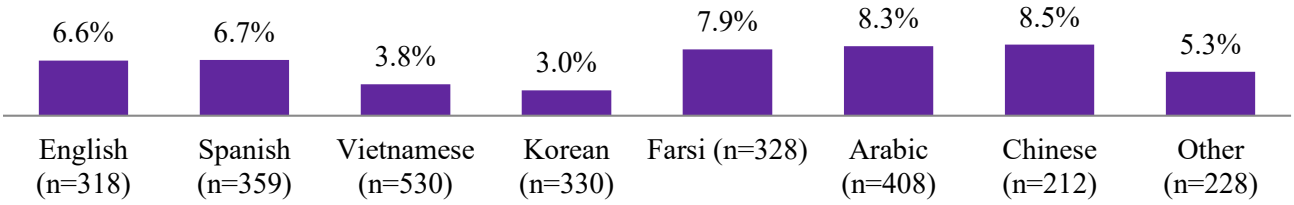
Region:



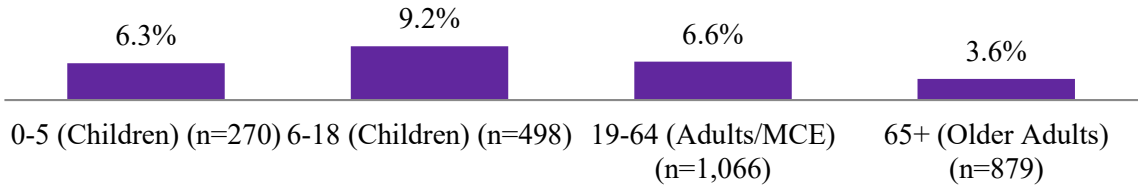
[8] Only reporting those who reported that they received at least one public benefit.

Receive TANF or CalWorks as a public benefit:

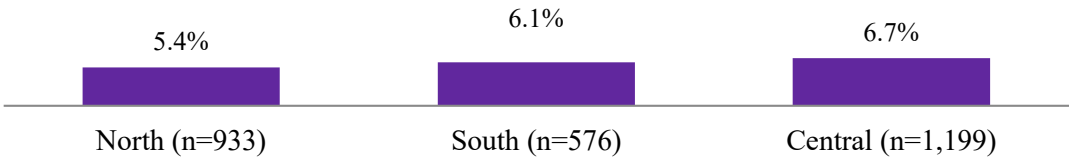
CalOptima language:



Age Category:

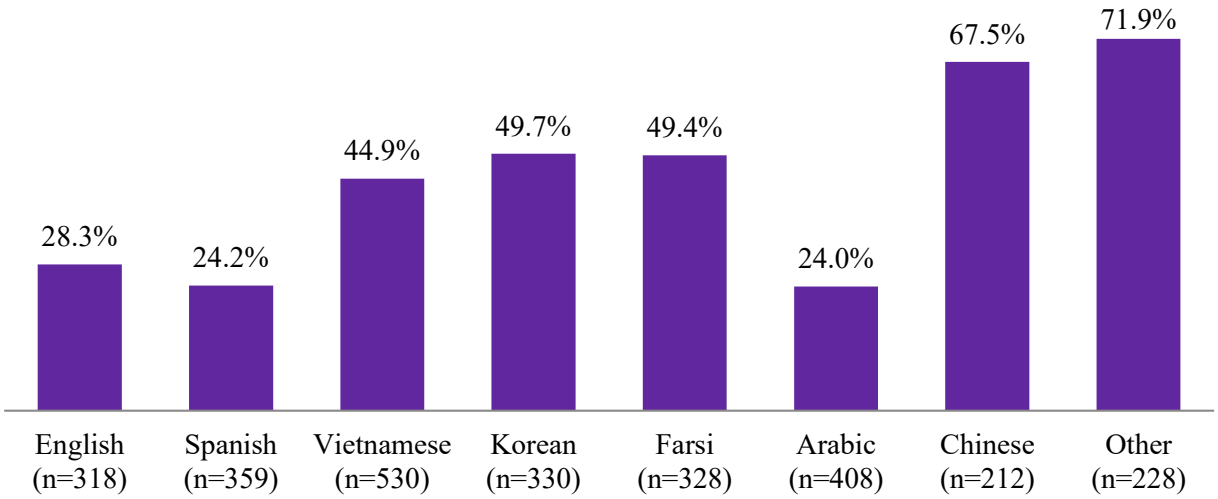


Region:

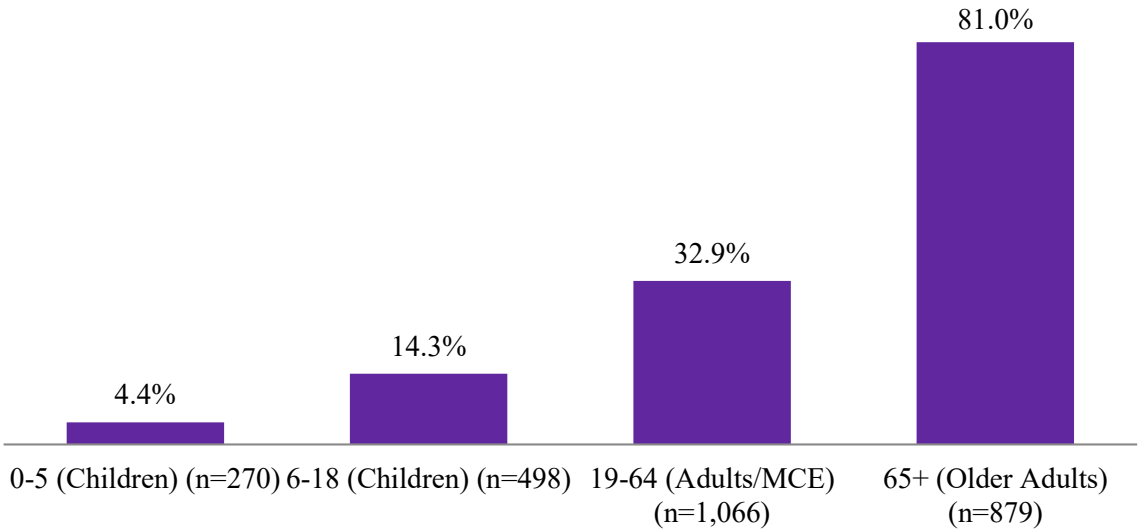


Receive SSI or SSDI as a public benefit:

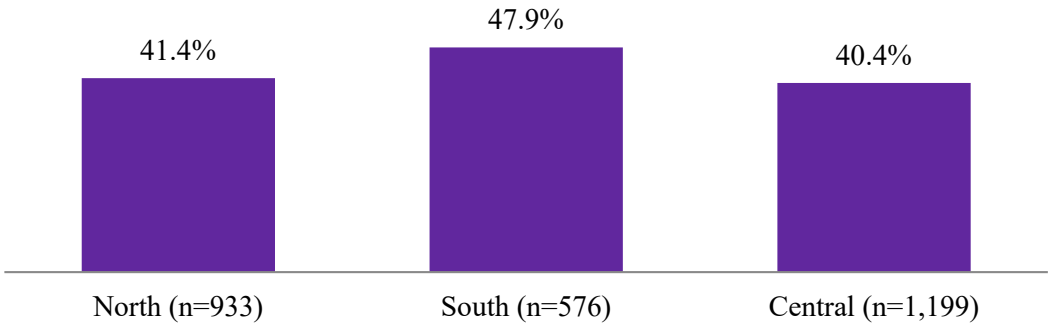
CalOptima language:



Age Category:

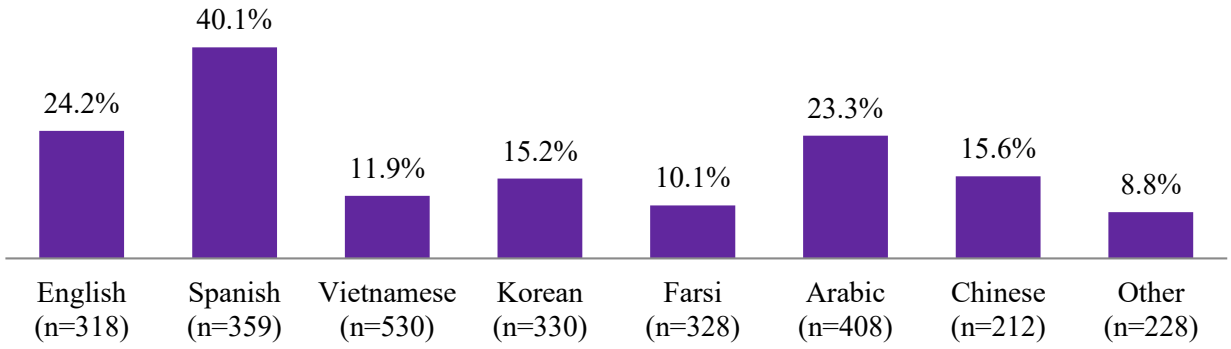


Region:

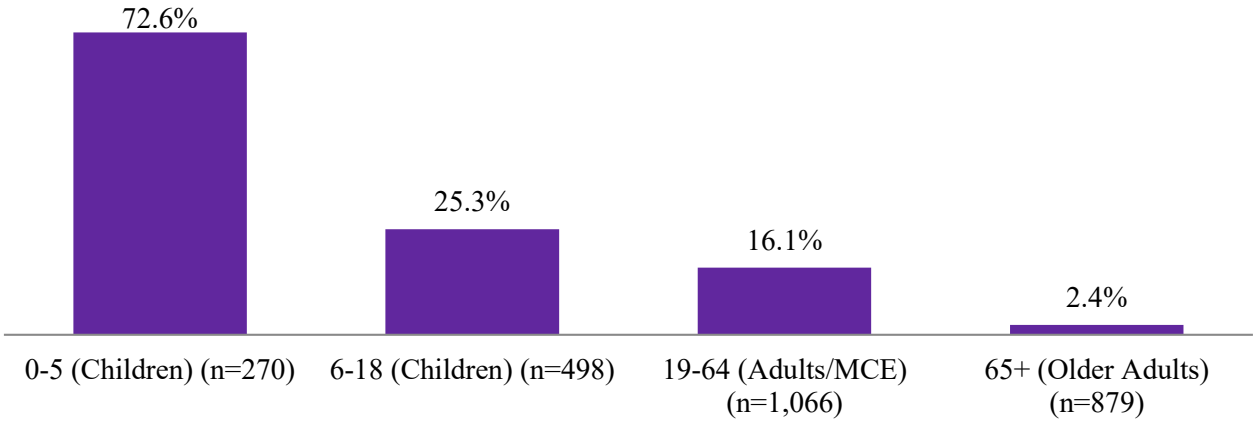


Receive WIC as a public benefit:

CalOptima language:



Age Category:



Region:

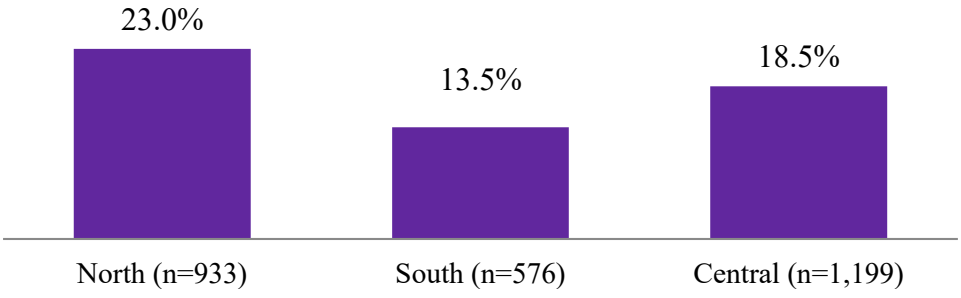


Exhibit 15. Personal activities participation:

CalOptima language:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	41.2%	6.4%	6.4%	45.9%	621
Spanish	19.1%	4.3%	3.1%	73.5%	607
Vietnamese	53.5%	3.3%	4.3%	38.9%	766
Korean	35.4%	6.3%	2.3%	56.0%	809
Farsi	28.5%	3.2%	3.4%	65.0%	537
Arabic	47.2%	5.9%	1.9%	45.0%	540
Chinese	16.8%	3.8%	3.1%	76.3%	583
Other	32.3%	4.0%	5.1%	58.6%	350
Do fun activities with others	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
English	63.3%	18.3%	7.4%	11.0%	635
Spanish	61.8%	13.0%	4.0%	21.2%	647
Vietnamese	49.6%	19.5%	9.3%	21.7%	789
Korean	51.9%	22.7%	7.3%	18.0%	859
Farsi	39.5%	25.0%	10.2%	**25.3%**	608
Arabic	54.8%	20.6%	6.7%	17.9%	586
Chinese	45.4%	12.1%	5.8%	**36.7%**	619
Other	46.3%	21.6%	11.6%	20.5%	361

Volunteer or charity	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	16.2%	15.8%	19.4%	48.6%	628
Spanish	15.9%	10.0%	9.9%	64.2%	628
Vietnamese	15.8%	19.1%	26.7%	38.3%	752
Korean	21.0%	13.2%	15.6%	50.2%	825
Farsi	15.4%	13.8%	19.9%	50.9%	578
Arabic	23.5%	18.1%	14.3%	44.2%	575
Chinese	16.5%	11.9%	14.0%	57.7%	607
Other	9.9%	7.0%	12.1%	71.0%	355

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	68.7%	11.5%	6.0%	13.7%	633
Spanish	66.0%	8.7%	2.8%	22.5%	644
Vietnamese	69.6%	6.6%	4.0%	19.8%	807
Korean	75.1%	10.1%	3.7%	11.2%	874
Farsi	68.9%	7.7%	5.6%	17.9%	627
Arabic	59.1%	11.8%	4.4%	24.7%	587
Chinese	71.9%	7.3%	3.8%	17.1%	661
Other	57.6%	10.2%	4.7%	27.5%	363

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	83.3%	6.0%	1.0%	9.6%	612
Spanish	85.1%	5.3%	1.0%	8.6%	590
Vietnamese	78.0%	5.1%	1.5%	15.4%	740
Korean	88.2%	6.3%	1.0%	4.5%	842
Farsi	84.3%	4.8%	1.9%	8.9%	516
Arabic	83.2%	5.5%	1.5%	9.8%	531
Chinese	86.9%	5.2%	1.1%	6.7%	610
Other	80.3%	6.7%	3.5%	9.5%	315

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	76.7%	12.2%	2.9%	8.2%	621
Spanish	80.1%	7.7%	2.9%	9.3%	613
Vietnamese	78.2%	7.7%	1.9%	12.1%	725
Korean	73.6%	13.8%	4.6%	8.0%	864
Farsi	78.4%	9.9%	3.7%	8.0%	538
Arabic	74.5%	11.4%	2.7%	11.4%	553
Chinese	85.9%	5.3%	2.4%	6.3%	618
Other	82.9%	9.2%	3.5%	4.4%	315

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	0.8%	1.1%	6.2%	91.9%	632
Spanish	0.2%	0.3%	2.5%	97.1%	651
Vietnamese	2.6%	0.6%	3.1%	93.7%	772
Korean	0.8%	0.8%	6.5%	91.8%	846
Farsi	1.3%	1.0%	2.9%	94.8%	594
Arabic	5.0%	2.4%	1.0%	91.6%	582
Chinese	7.5%	2.3%	3.3%	86.8%	598
Other	2.2%	2.0%	8.1%	87.7%	358

Age Category:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	32.2%	3.4%	2.0%	62.4%	348
6-18 (Children)	33.0%	3.9%	2.5%	60.6%	1,077
19-64 (Adults/MCE)	43.2%	5.6%	4.2%	47.0%	2,093
65+ (Older Adults)	24.3%	4.3%	4.2%	67.2%	1,295

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	75.0%	9.8%	2.9%	12.2%	376
6-18 (Children)	72.5%	12.3%	4.7%	10.6%	1,137
19-64 (Adults/MCE)	43.6%	24.2%	9.3%	23.0%	2,190
65+ (Older Adults)	41.9%	19.2%	8.6%	30.3%	1,401

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	14.5%	10.4%	11.0%	64.1%	365
6-18 (Children)	22.7%	18.3%	17.2%	41.8%	1,117
19-64 (Adults/MCE)	18.0%	14.9%	20.8%	46.3%	2,142
65+ (Older Adults)	12.1%	10.1%	12.2%	65.6%	1,324

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	69.2%	7.0%	1.9%	21.9%	370
6-18 (Children)	77.9%	8.4%	3.2%	10.5%	1,148
19-64 (Adults/MCE)	62.2%	12.6%	5.7%	19.5%	2,211
65+ (Older Adults)	69.3%	4.9%	3.6%	22.2%	1,467

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	89.8%	3.6%	0.6%	6.1%	362
6-18 (Children)	90.2%	4.5%	0.9%	4.3%	1,084
19-64 (Adults/MCE)	80.5%	6.7%	1.7%	11.0%	2,061
65+ (Older Adults)	82.4%	5.2%	1.6%	10.8%	1,249

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	79.0%	6.4%	3.6%	11.0%	362
6-18 (Children)	83.2%	7.7%	2.4%	6.7%	1,110
19-64 (Adults/MCE)	70.7%	14.3%	4.3%	10.8%	2,105
65+ (Older Adults)	86.5%	5.3%	1.7%	6.5%	1,270

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	3.0%	0.5%	1.6%	94.8%	368
6-18 (Children)	2.3%	0.6%	1.8%	95.3%	1,134
19-64 (Adults/MCE)	1.9%	1.0%	5.4%	91.7%	2,171
65+ (Older Adults)	3.2%	2.3%	4.6%	89.9%	1,360

Region:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	35.3%	5.4%	3.7%	55.6%	1,639
South	28.8%	4.2%	4.0%	62.9%	1,252
Central	38.8%	4.4%	3.4%	53.4%	1,910

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	51.8%	20.1%	8.0%	20.0%	1,757
South	47.7%	21.1%	8.0%	23.2%	1,345
Central	55.0%	16.6%	6.9%	21.5%	1,989

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	17.7%	13.8%	16.0%	52.5%	1,702
South	16.8%	13.2%	16.8%	53.3%	1,307
Central	17.1%	14.9%	17.9%	50.1%	1,927

Physical fitness	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	67.4%	10.2%	4.9%	17.5%	1,780
South	69.4%	8.8%	4.4%	17.4%	1,387
Central	67.9%	8.3%	3.7%	20.1%	2,017

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	86.8%	4.7%	0.8%	7.7%	1,668
South	86.0%	5.3%	1.8%	6.9%	1,230
Central	79.9%	6.6%	1.7%	11.8%	1,848

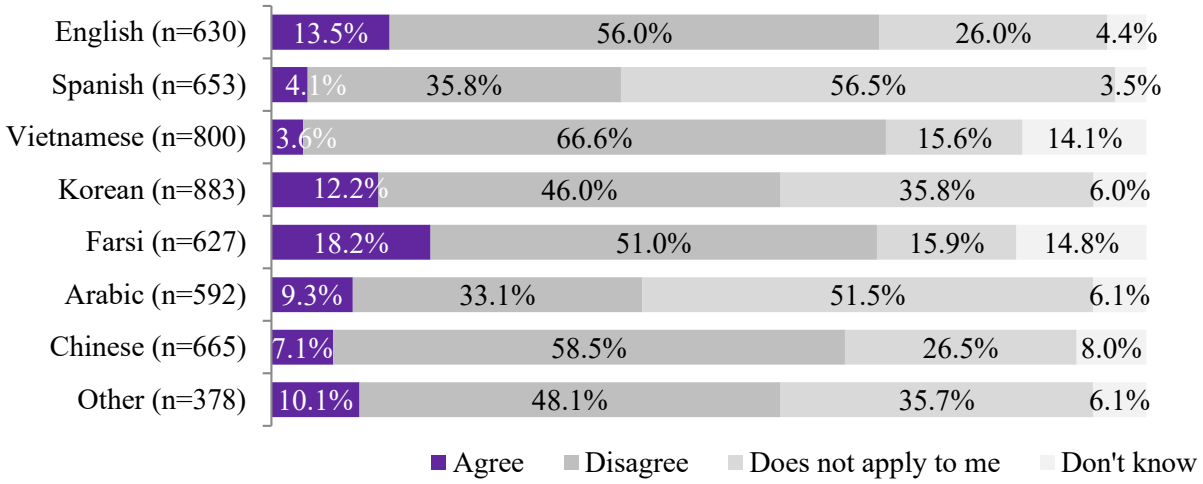
Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	76.2%	10.9%	3.8%	9.1%	1,694
South	81.0%	9.2%	3.3%	6.5%	1,263
Central	78.5%	9.2%	2.3%	9.9%	1,880

Visit a casino or gamble on the internet	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	1.5%	0.9%	4.5%	93.2%	1,726
South	4.0%	1.1%	3.7%	91.3%	1,327
Central	2.2%	1.7%	4.0%	92.1%	1,969

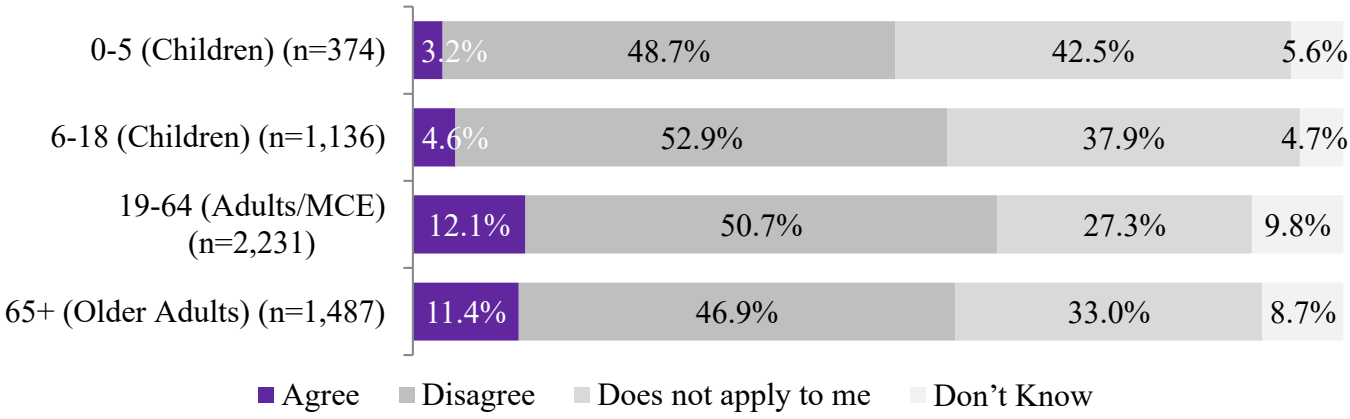
Exhibit 16. Feelings towards community and home enviroment:

Feeling lonely and isolated:

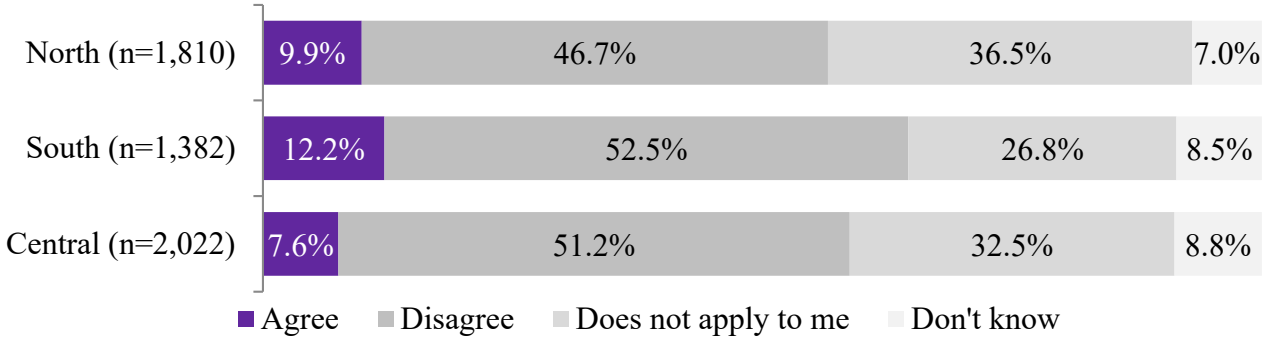
CalOptima language:



Age Category:

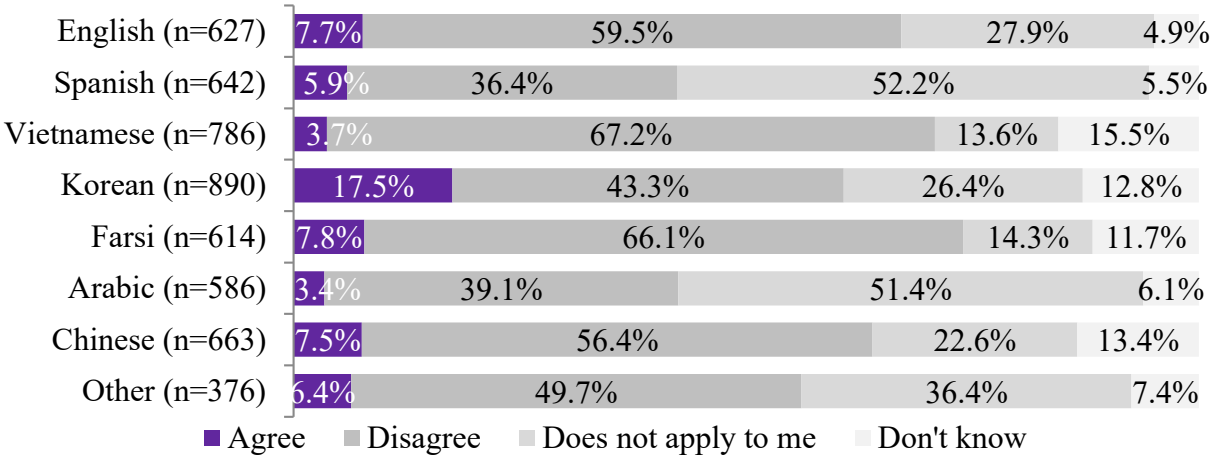


Region:

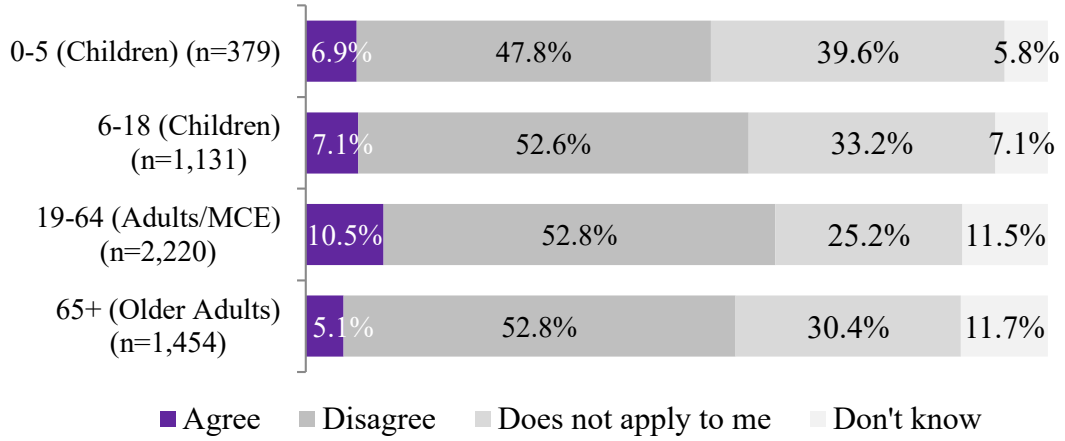


Feel not treated equally because of ethnic and culutral backgrounds:

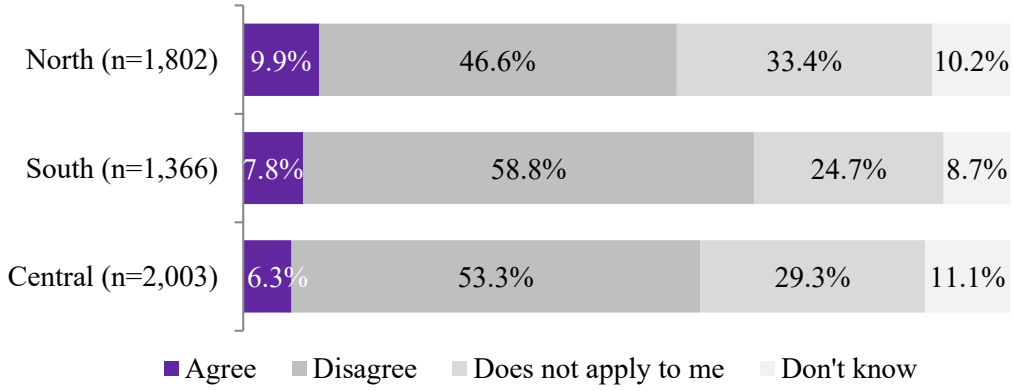
CalOptima language:



Age Category:

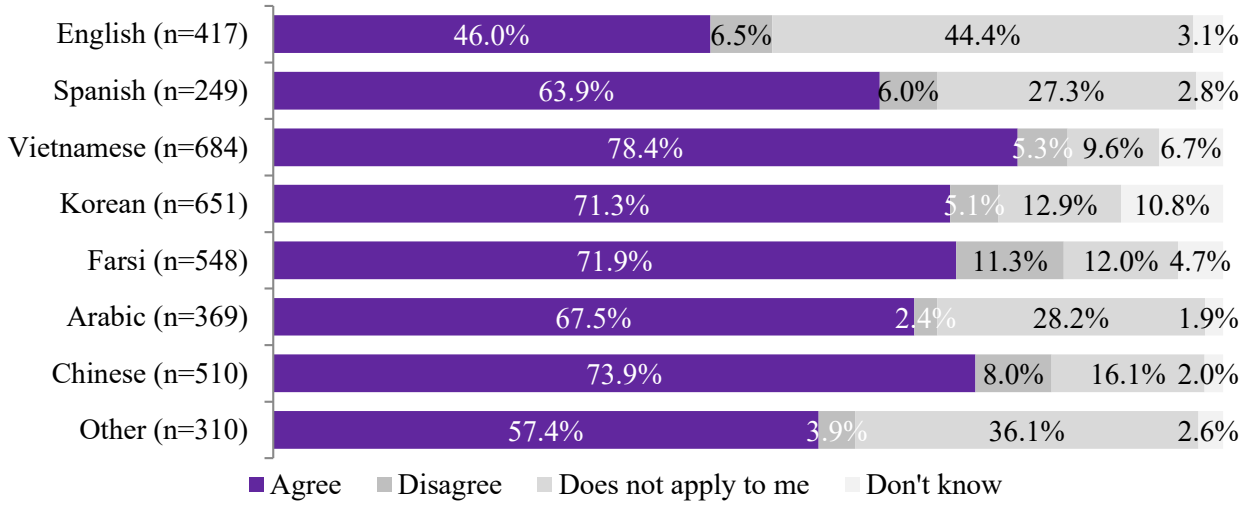


Region:



Feel child respects them as a parent[9]:

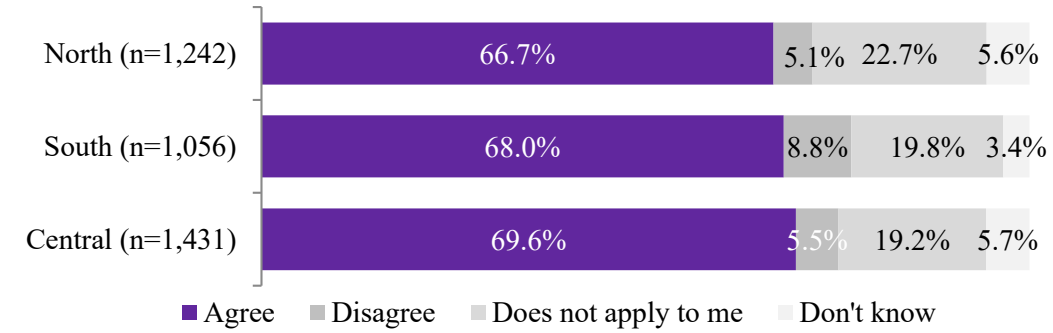
CalOptima language:



Age Category:



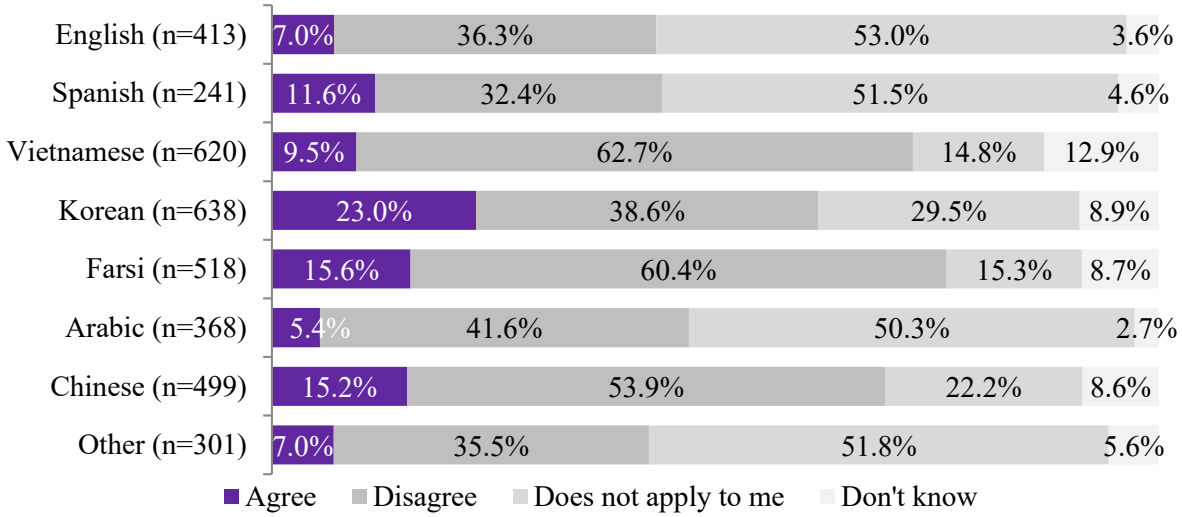
Region:



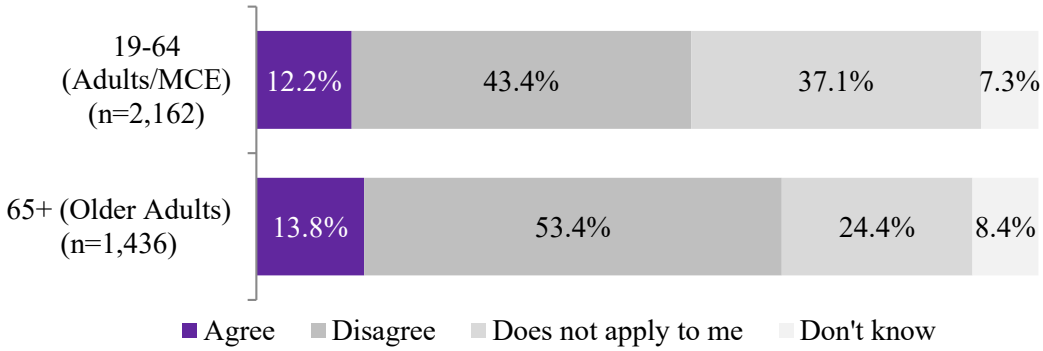
[9] Only reported those who are over 18 years old.

Feel child's attitudes and behavior conflict with cultural values[10]:

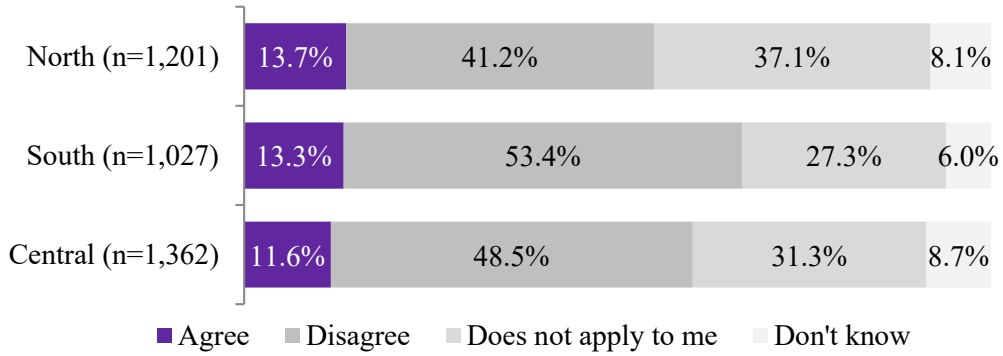
CalOptima language:



Age Category:



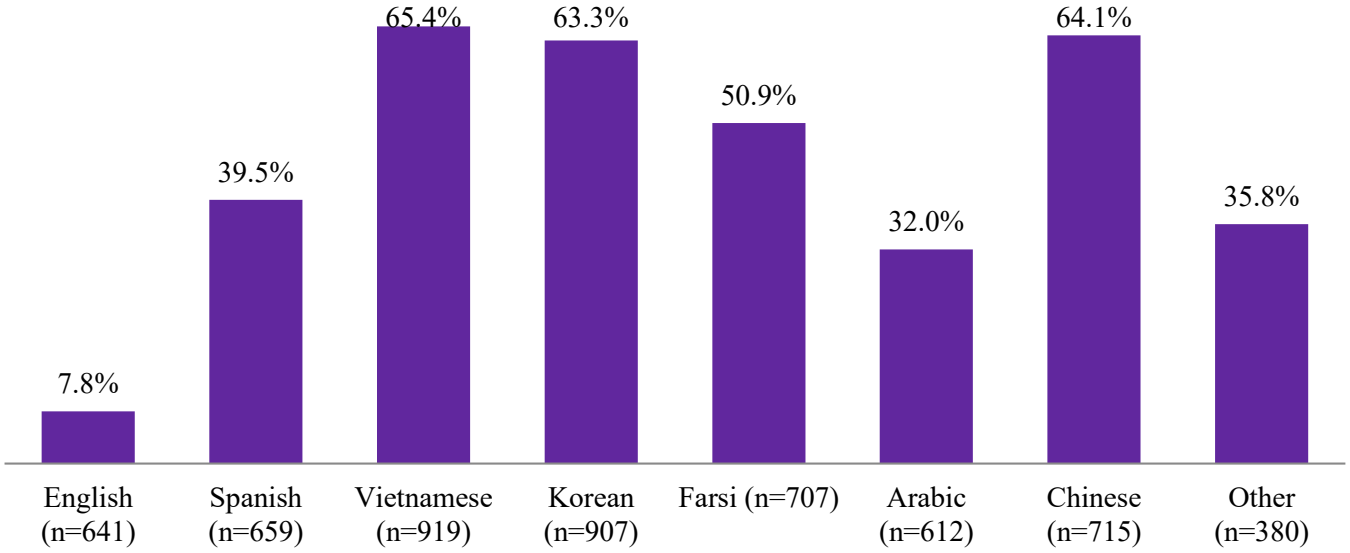
Region:



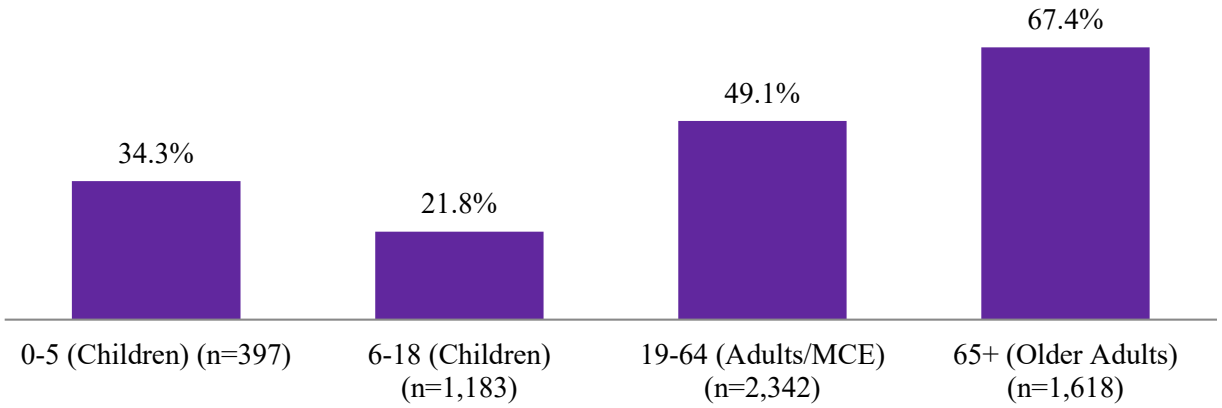
[10] Only reported those who are over 18 years old.

Exhibit 17. Members who reported that they speak English "not well":

CalOptima language:



Age Category:



Region:

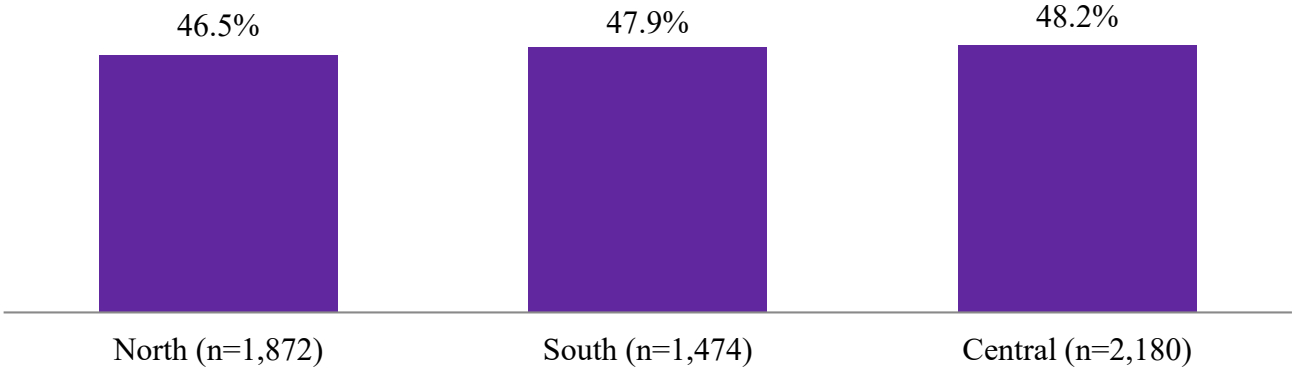


Exhibit 18. Employment status[11,12]

CalOptima language:

CalOptima language	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
English	36.7%	9.8%	7.2%	9.4%	13.4%	15.8%	20.4%	417
Spanish	21.7%	7.8%	11.6%	4.7%	21.3%	17.1%	28.3%	258
Vietnamese	32.1%	1.8%	12.1%	6.6%	24.4%	17.0%	20.0%	761
Korean	18.2%	11.6%	21.3%	6.9%	24.5%	10.0%	16.5%	638
Farsi	18.0%	4.4%	15.3%	7.6%	19.5%	26.5%	29.9%	616
Arabic	25.5%	4.2%	21.1%	9.4%	15.7%	11.9%	22.0%	427
Chinese	14.0%	3.8%	14.2%	4.9%	45.0%	6.8%	19.5%	529
Other	15.7%	3.4%	8.9%	3.7%	37.5%	10.2%	30.8%	325

Age Category:

Age Category	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
19-64 (Adults/MCE)	35.8%	8.3%	17.5%	10.9%	5.9%	17.6%	15.3%	2,370
65+ (Older Adults)	4.1%	1.7%	10.1%	0.7%	53.7%	10.5%	33.3%	1,601

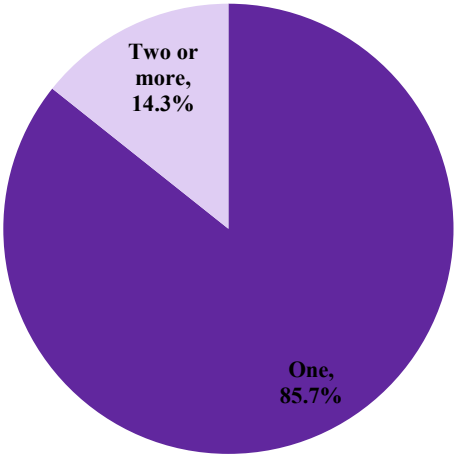
Region:

Region	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
North	24.0%	6.7%	15.9%	6.7%	23.6%	12.7%	22.5%	1,269
South	17.3%	6.6%	16.7%	7.3%	26.6%	17.3%	22.1%	1,129
Central	26.1%	4.0%	11.7%	6.5%	25.6%	14.7%	23.2%	1,561

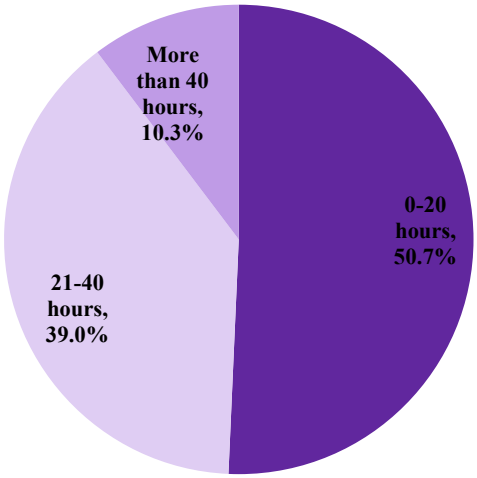
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]

Number of jobs members have

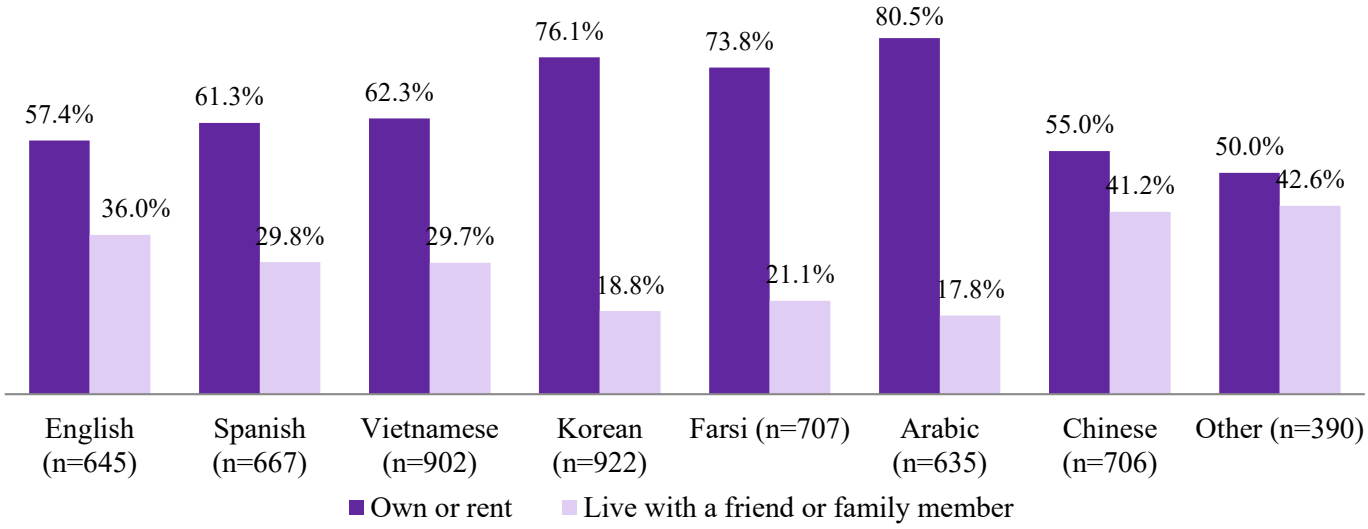


Number of hours that members work each week

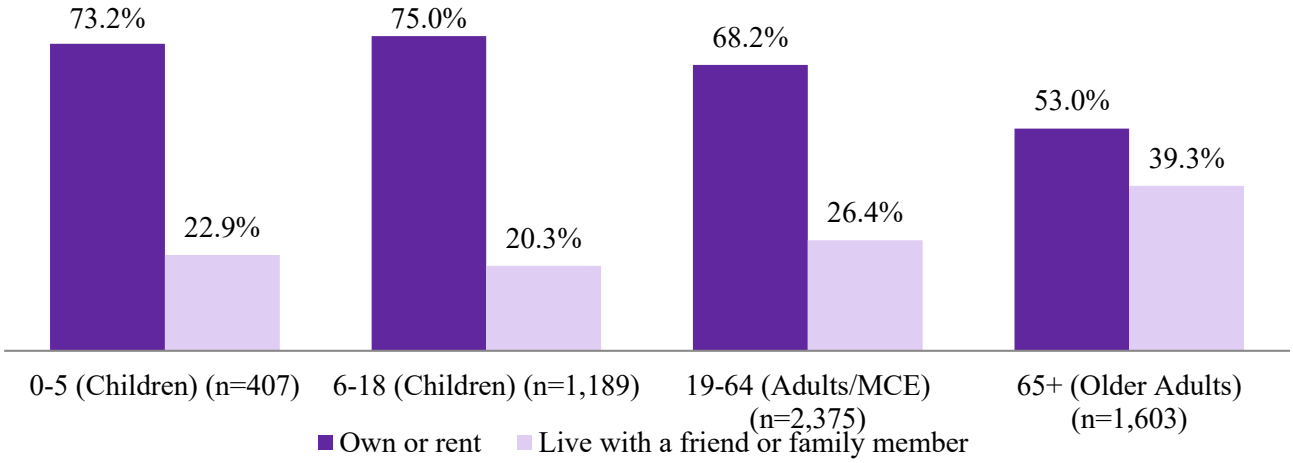


[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

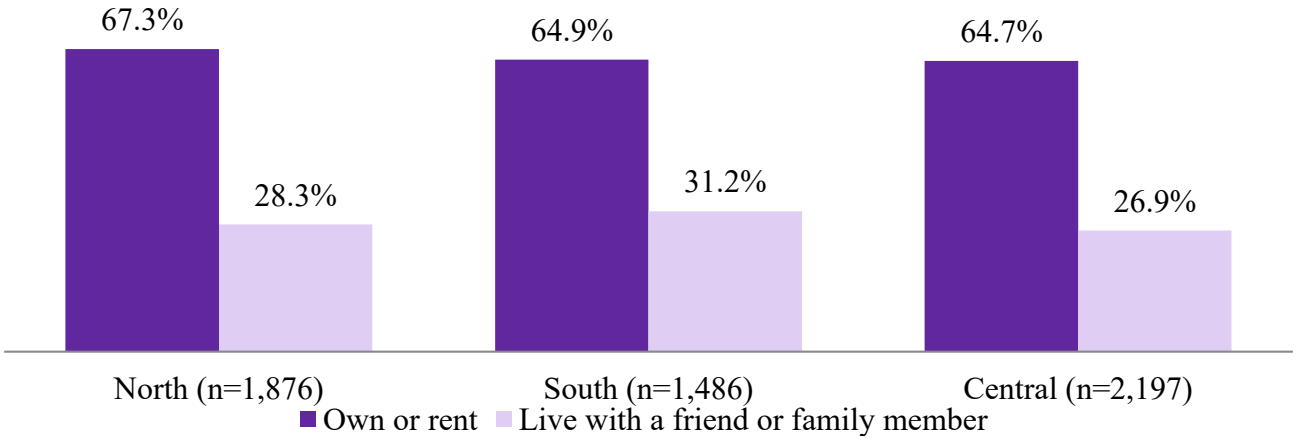
Exhibit 20. Members' living situation[14]



Age Category:



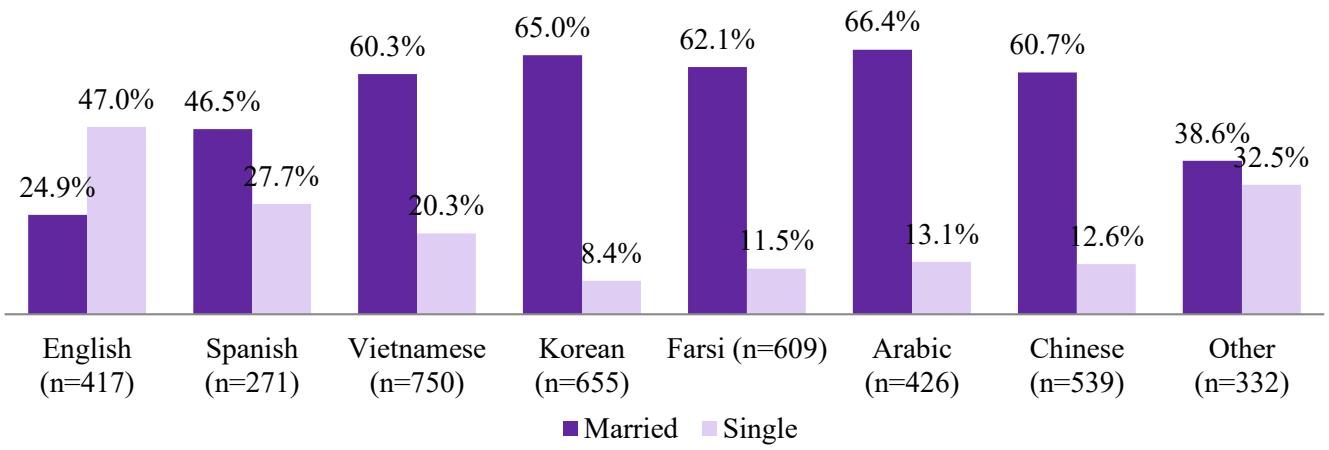
Region:



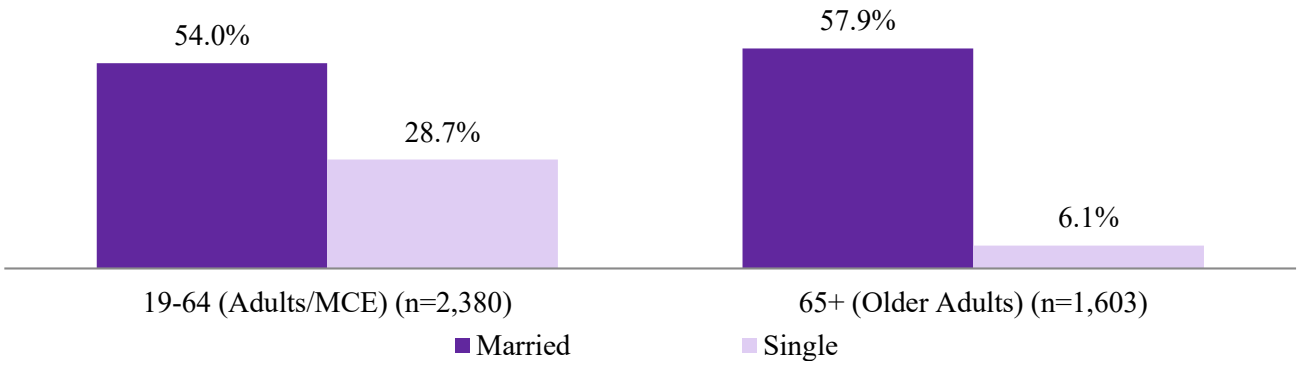
[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

Exhibit 21. Marital status of members[15],[16]

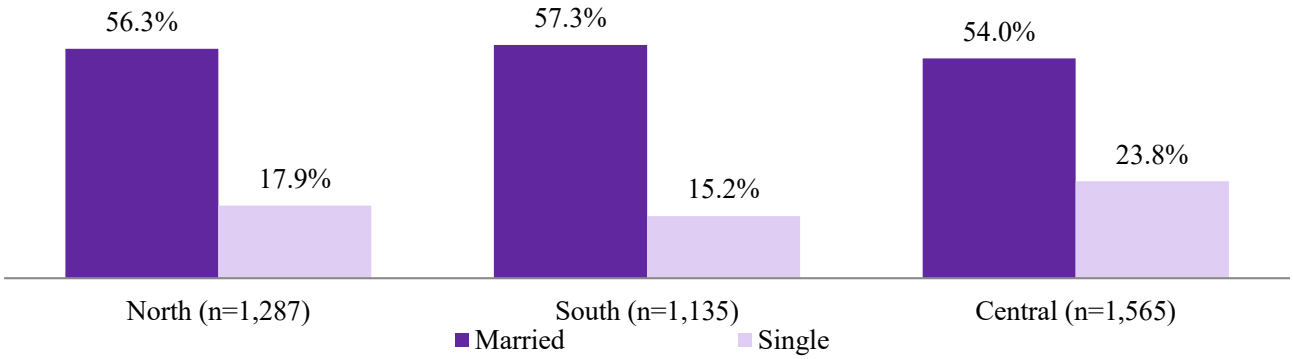
CalOptima language:



Age Category:



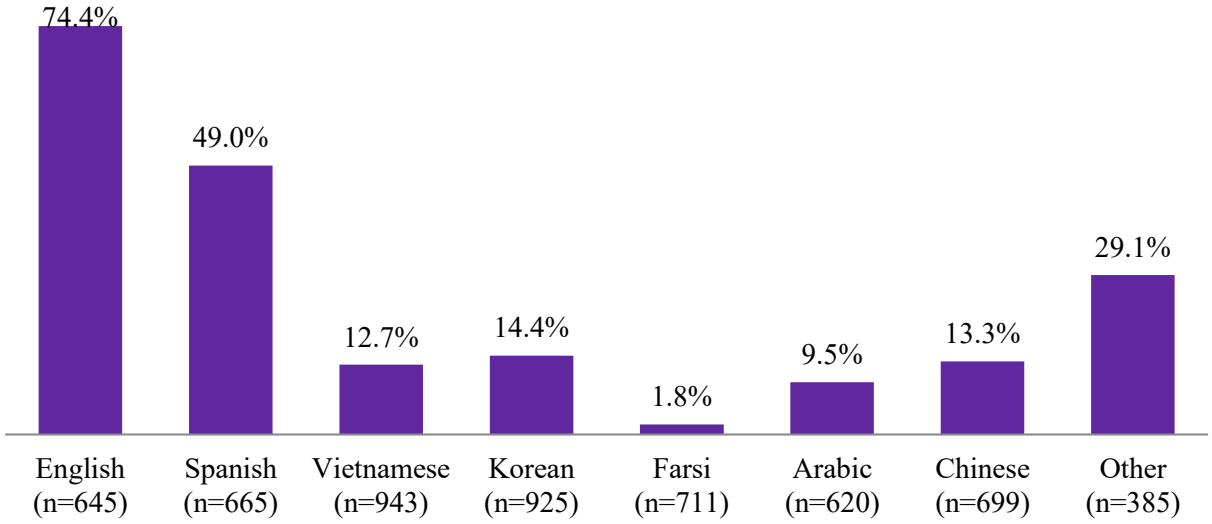
Region:



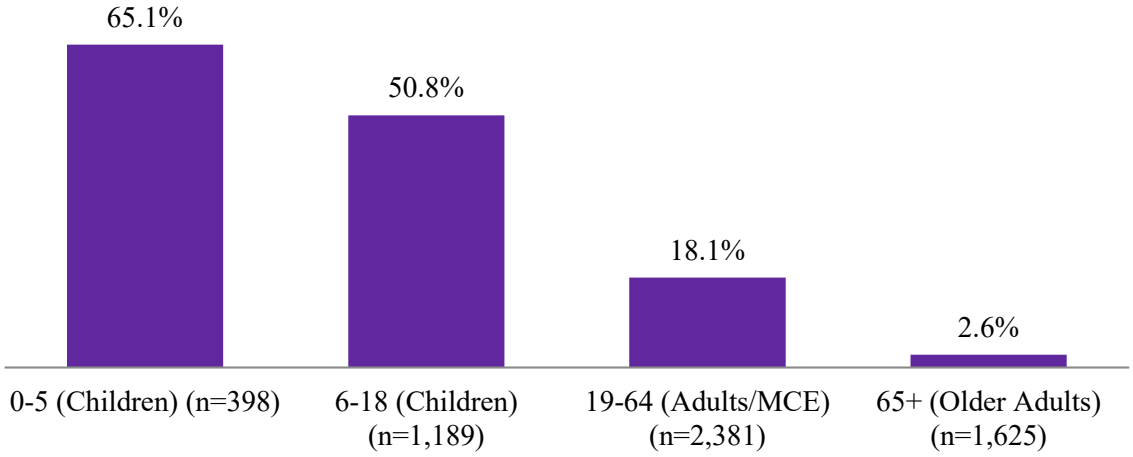
[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

Exhibit 22. Percent of members who were born in the United States:

CalOptima language:



Age Category:



Region:

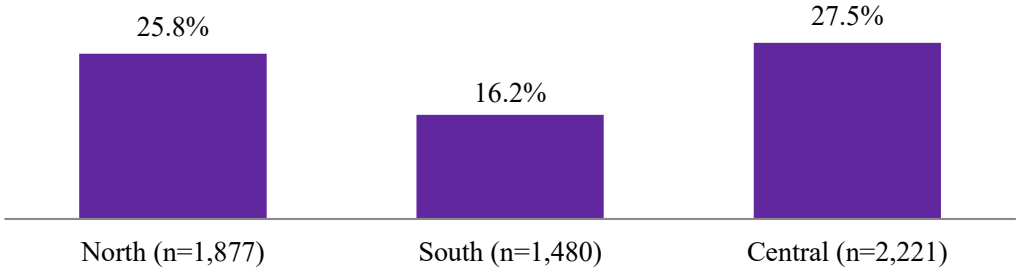
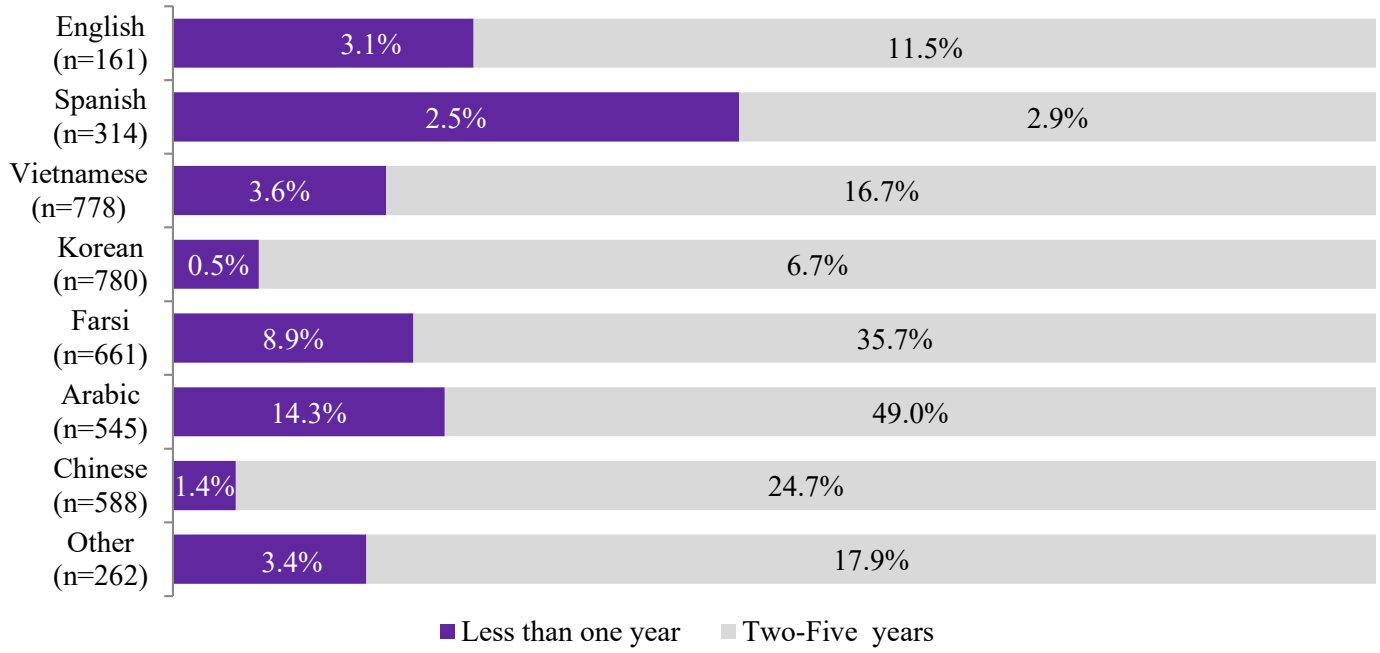
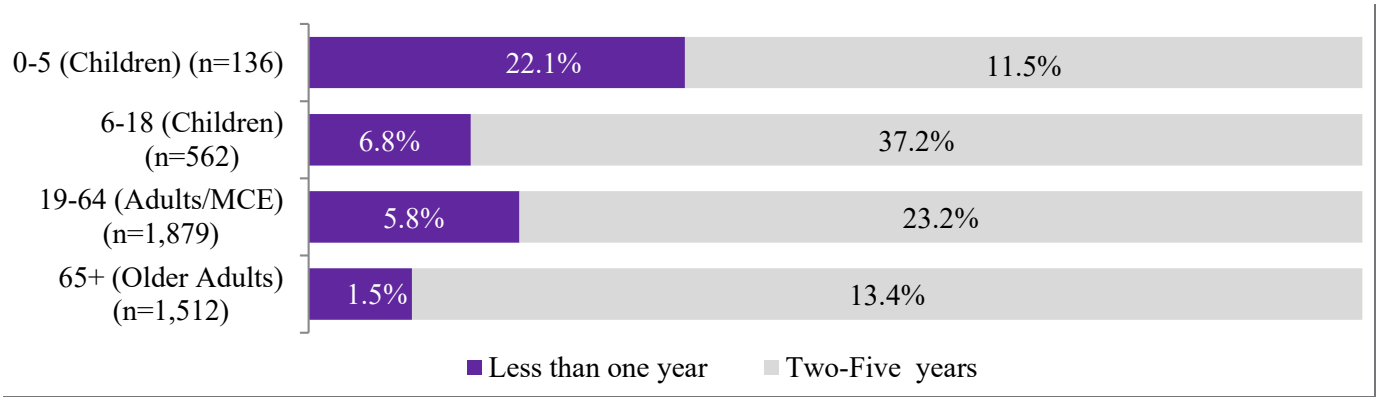


Exhibit 23. Length of time lived in the United States of those not born in the United States

CalOptima language:



Age Category:



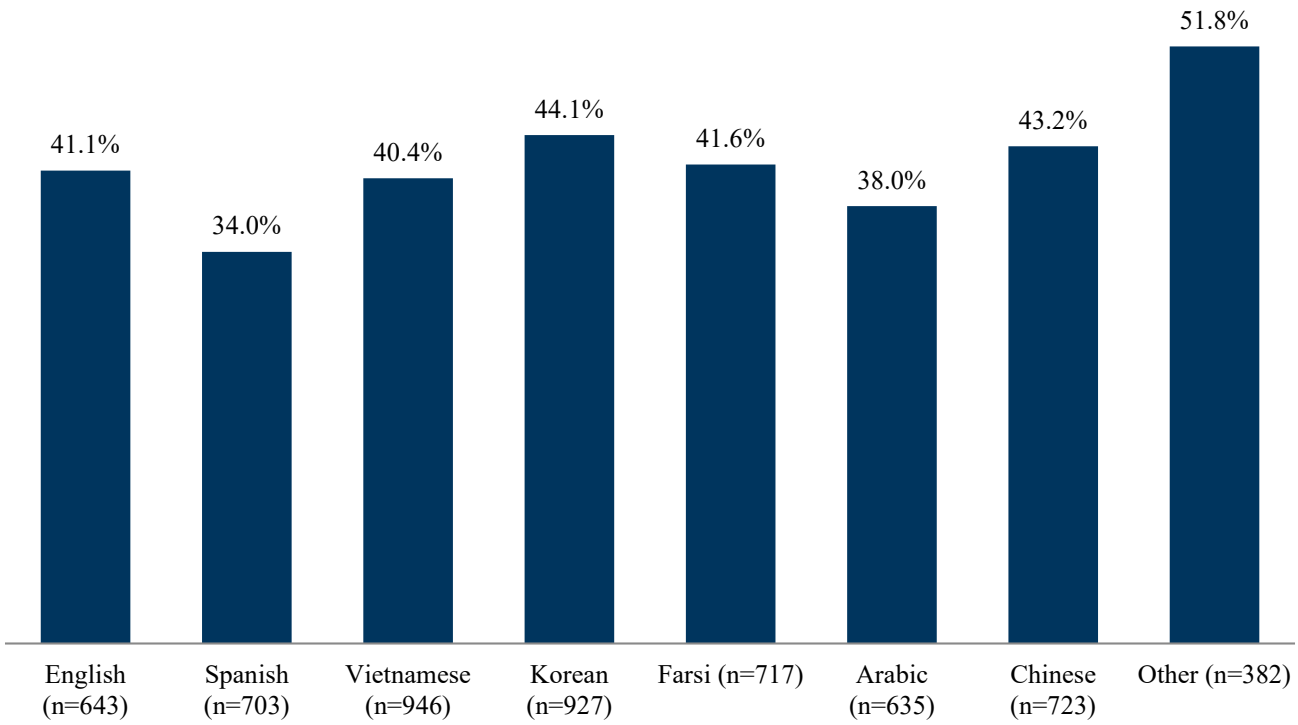
Region:



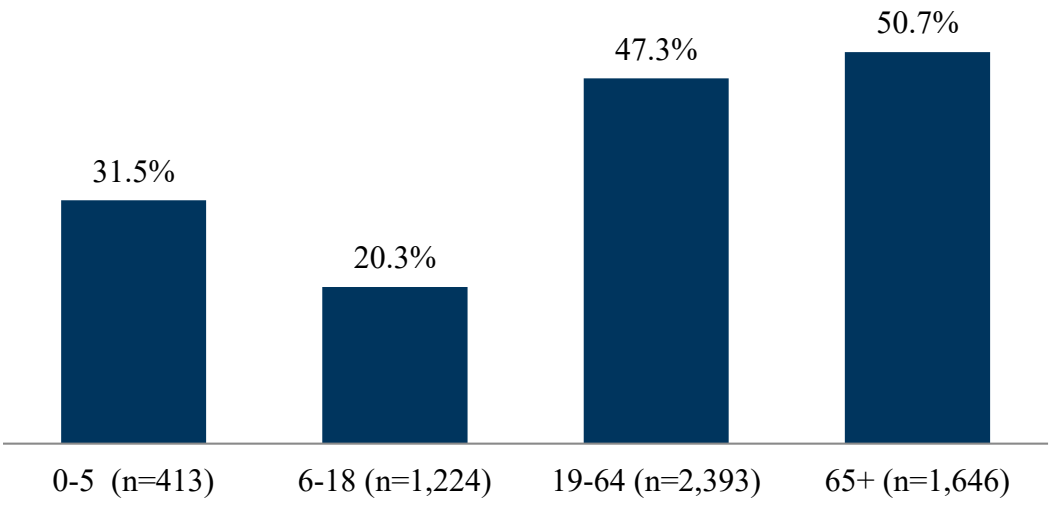
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:



Age Category:



Region:

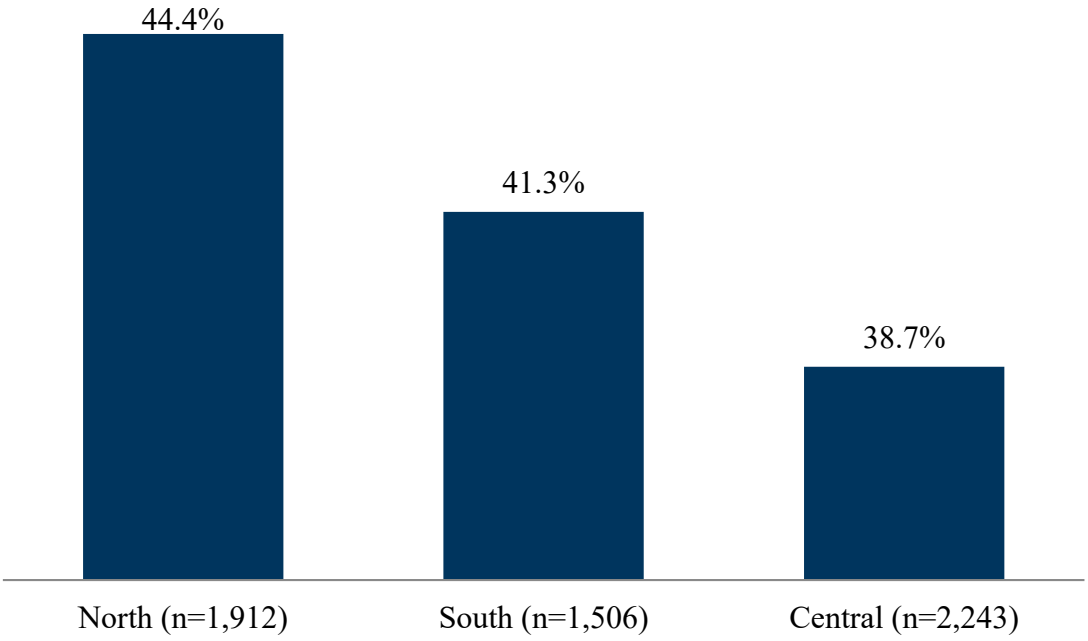


Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]

CalOptima Language:

CalOptima Language	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
English	43.8%	28.3%	6.6%	8.1%	258
Spanish	39.5%	17.6%	4.9%	12.2%	205
Vietnamese	26.6%	15.7%	5.0%	13.0%	338
Korean	64.2%	35.3%	4.1%	5.1%	391
Farsi	53.1%	23.8%	5.1%	8.1%	273
Arabic	62.9%	16.3%	1.8%	11.8%	221
Chinese	40.6%	21.1%	7.7%	14.1%	298
Other	33.1%	23.2%	5.5%	12.7%	181

Age Category:

CalOptima Age Category	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
0-5 (Children)	19.5%	23.7%	3.4%	14.4%	118
6-18 (Children)	34.7%	25.6%	1.8%	15.1%	219
19-64 (Adults/MCE)	52.7%	27.3%	4.1%	9.0%	1,062
65+ (Older Adults)	19.5%	23.7%	3.4%	14.4%	766

[17] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

[18] Only reported those who have not seen a dentist within the past 12 months.

Region:

CalOptima Region	Cost	Don't have/know dentist	No transportation	Don't know	n
	%	%	%	%	
North	48.9%	22.3%	5.5%	9.9%	798
South	51.6%	28.2%	4.6%	9.4%	585
Central	39.2%	20.9%	5.2%	11.3%	776

Exhibit 26. Days per week member had at least one drink of alcoholic beverage during the past 30 days [19]

CalOptima language:

CalOptima Language	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
English	71.7%	19.6%	4.0%	2.0%	2.7%	403
Spanish	83.5%	10.4%	1.3%	0.9%	3.9%	230
Vietnamese	81.3%	10.7%	1.9%	1.8%	4.3%	738
Korean	77.1%	15.5%	3.0%	1.5%	2.9%	593
Farsi	74.8%	19.3%	1.2%	0.2%	4.4%	497
Arabic	87.6%	4.5%	0.6%	0.8%	6.5%	355
Chinese	84.9%	8.0%	1.2%	0.6%	5.4%	503
Other	83.7%	7.7%	1.6%	1.3%	5.8%	312

Age Category:

CalOptima Age Category	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
19-64 (Adults/MCE)	78.7%	13.0%	2.3%	1.0%	4.9%	2,163
65+ (Older Adults)	82.2%	11.4%	1.4%	1.4%	3.5%	1,468

[19] Only reported those who are 18 years or older.

Region:

CalOptima Region	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
North	81.1%	11.9%	1.2%	1.5%	4.3%	1,156
South	79.5%	14.5%	1.8%	0.7%	3.5%	1,000
Central	79.7%	11.4%	2.5%	1.3%	5.1%	1,465

January 2018

CalOptima Member Survey Data Book:

Weighted Population Estimates

harder+co | community research

CalOptima A Public Agency Better. Together.

Navigating the Healthcare System

Exhibit 27. Percent who report at least one person as their doctor (n=5,749)

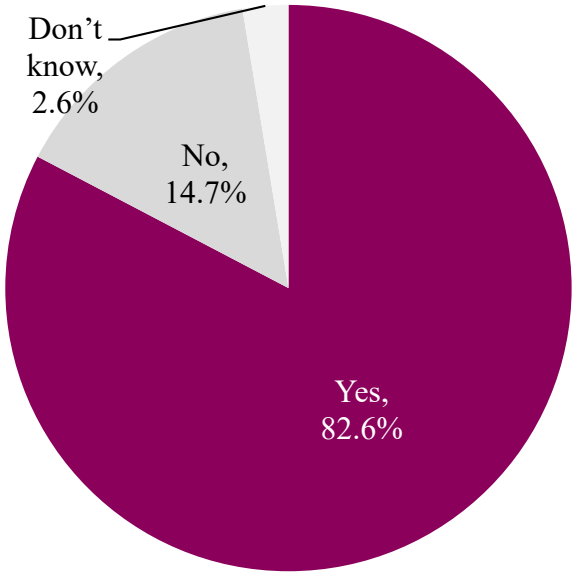


Exhibit 28. Where respondents go to see their doctor (n=5,743)

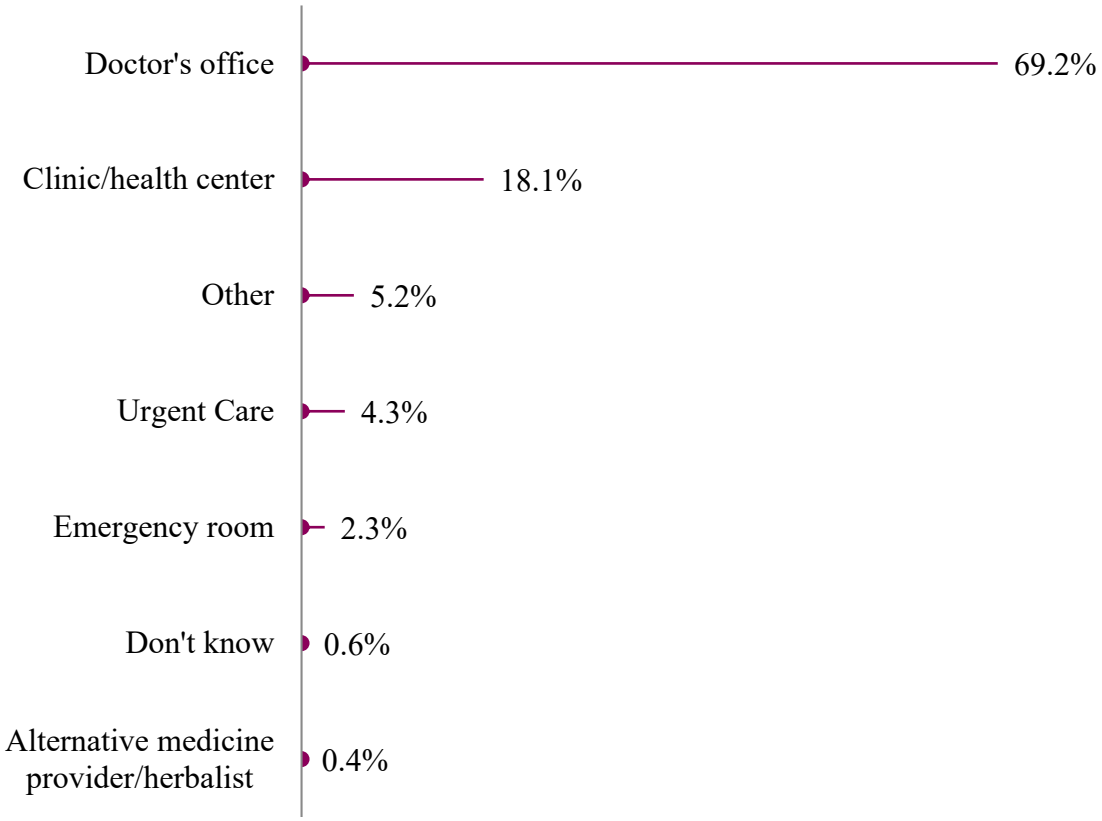


Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

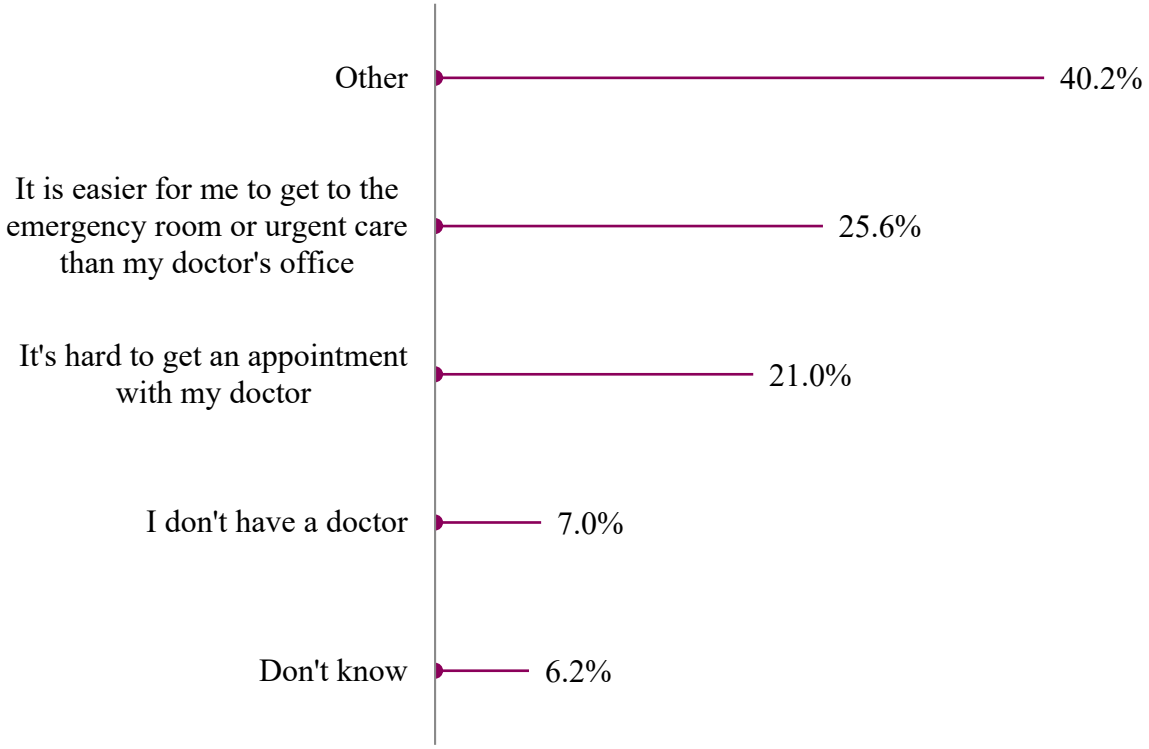


Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]

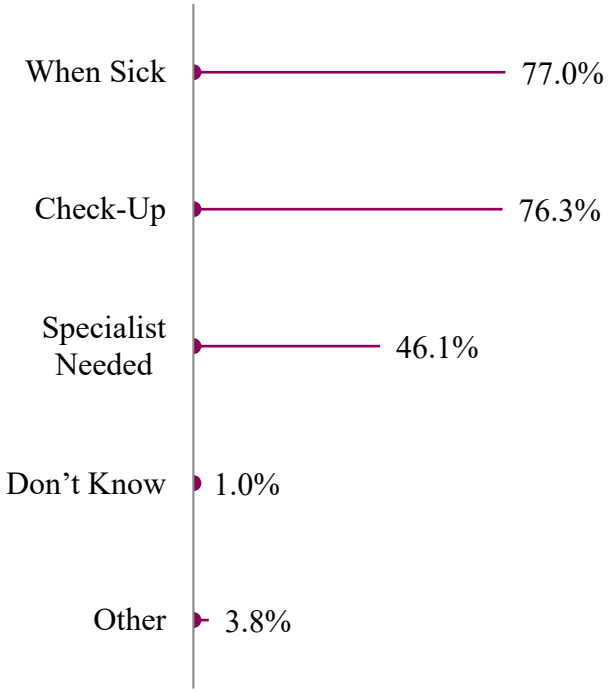
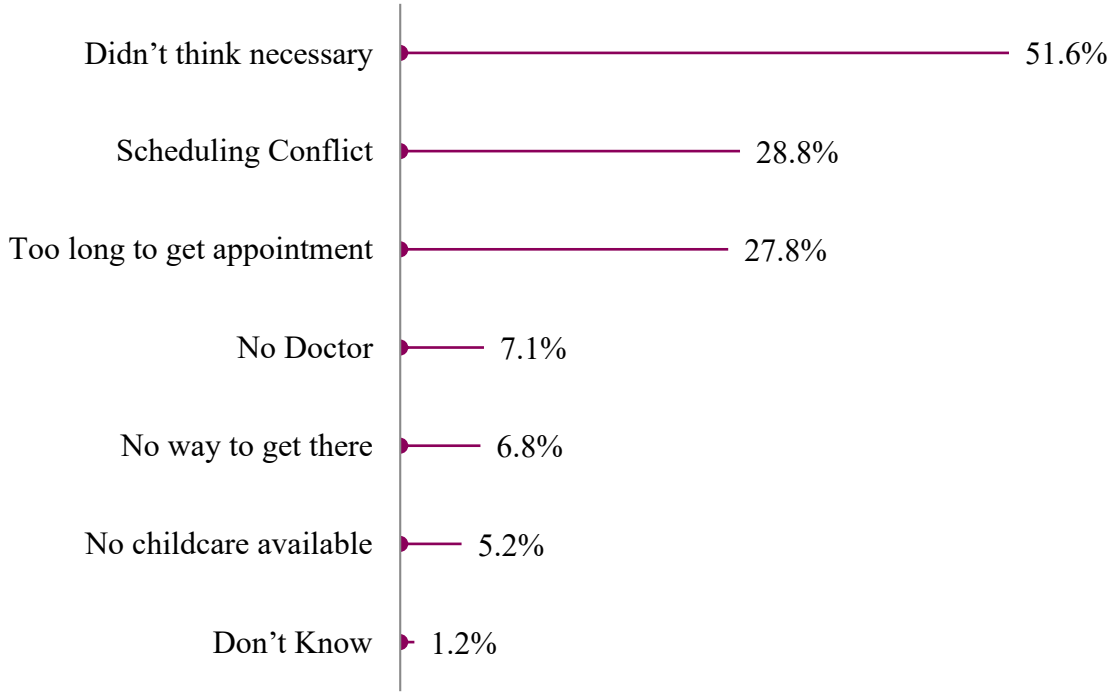


Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]



[20] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[21] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 32. When do members make an appointment to see a specialist (n=5,590)[22]

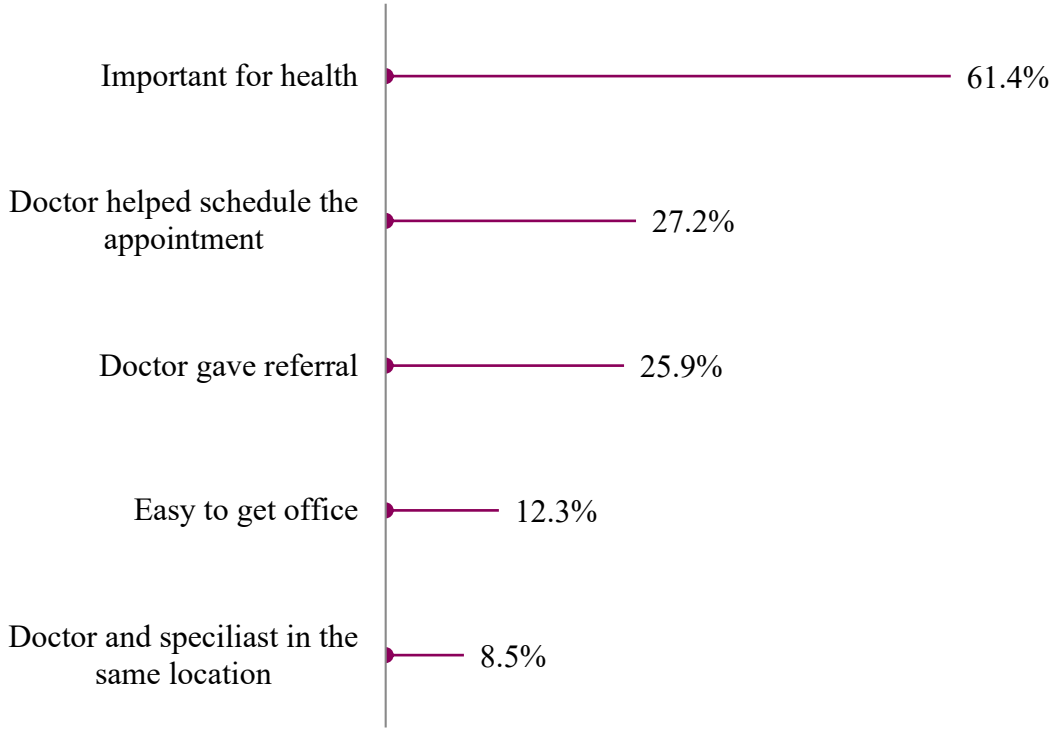
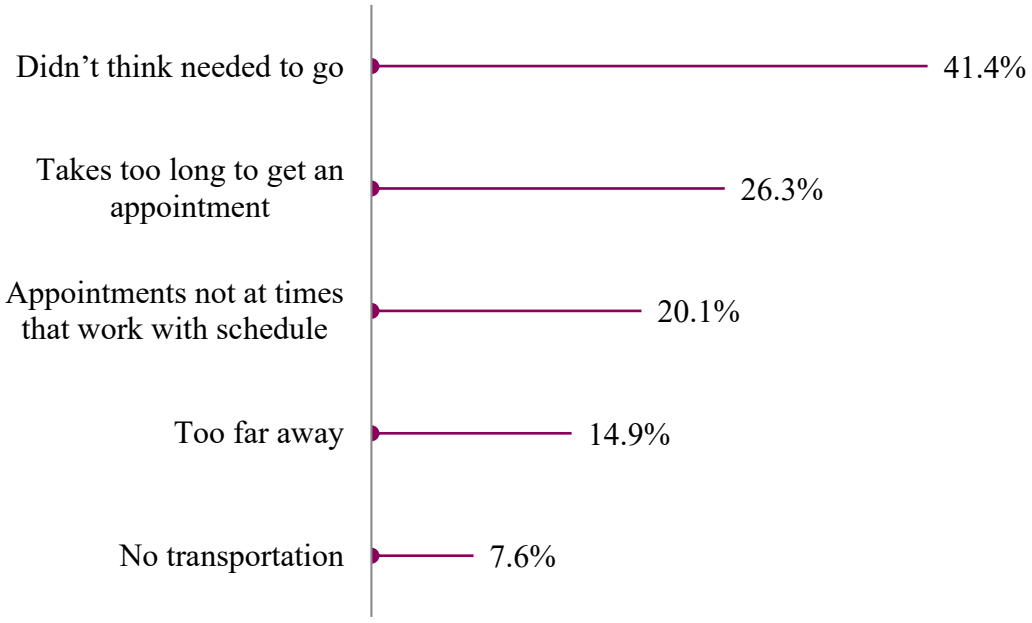
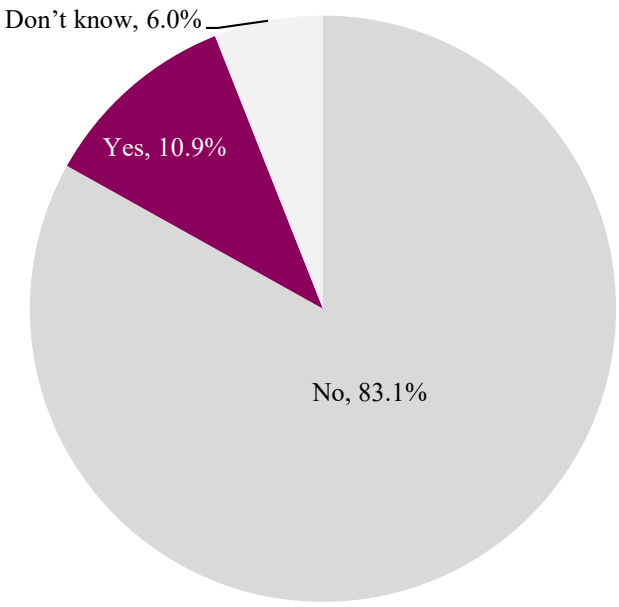


Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]



[22] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[23] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 34. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor (n=4,955)



Social and Emotional Well-Being

Exhibit 35. Percent of members who indicated they needed to see a mental health specialist (n=5,723)

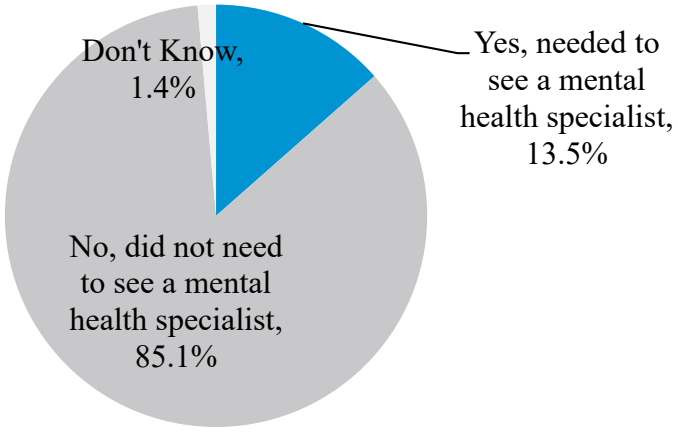


Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)

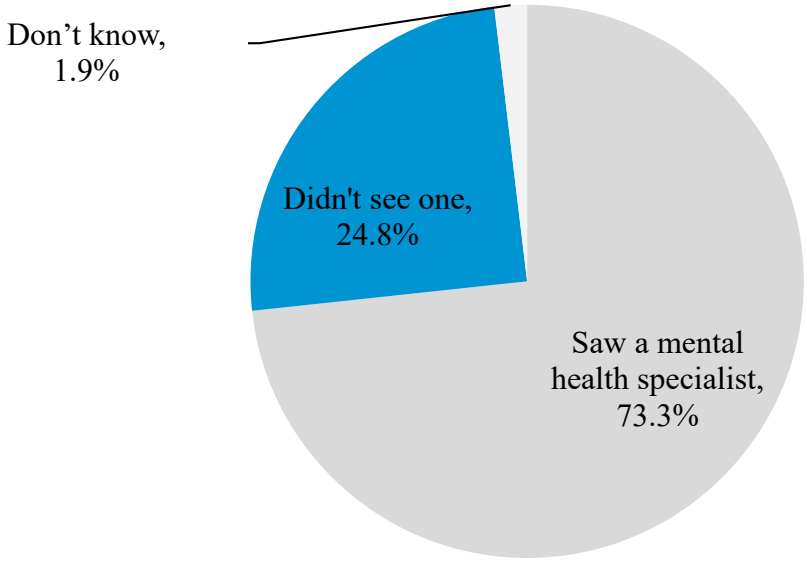


Exhibit 37. Reasons why members didn't see mental health specialist[24]

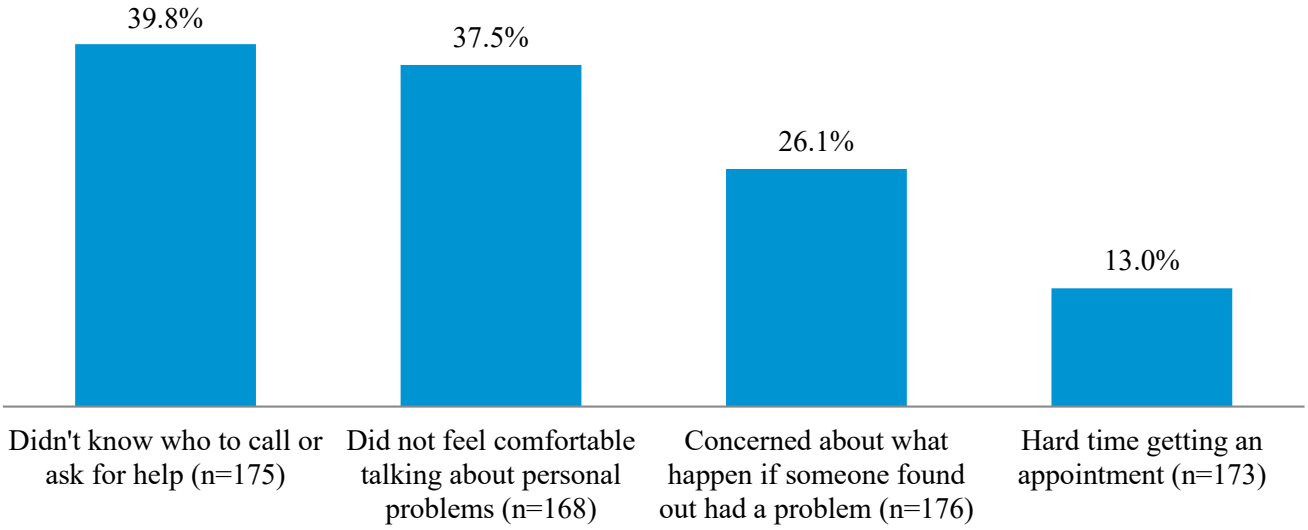
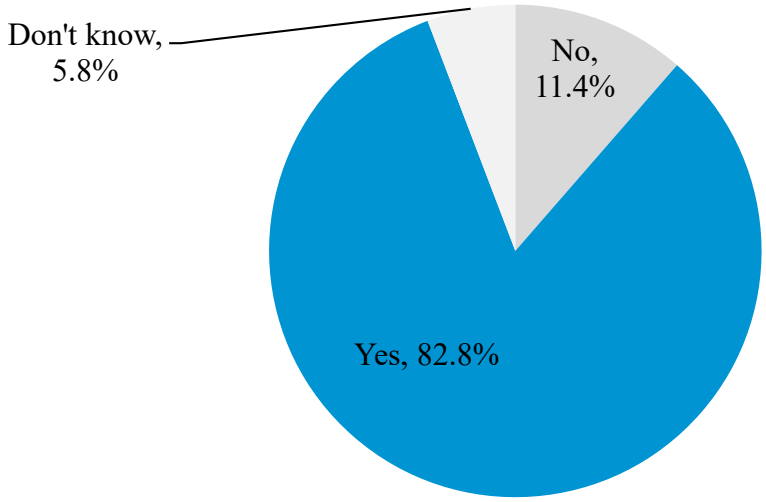


Exhibit 38. Percent of members who can share their worries with family members (n=5,670)



[24] Among those who indicated that they needed to see a mental health specialist but did not see one.

Social Determinants of Health

Exhibit 39. Percent of members who needed help with basic needs in the past 6 months:

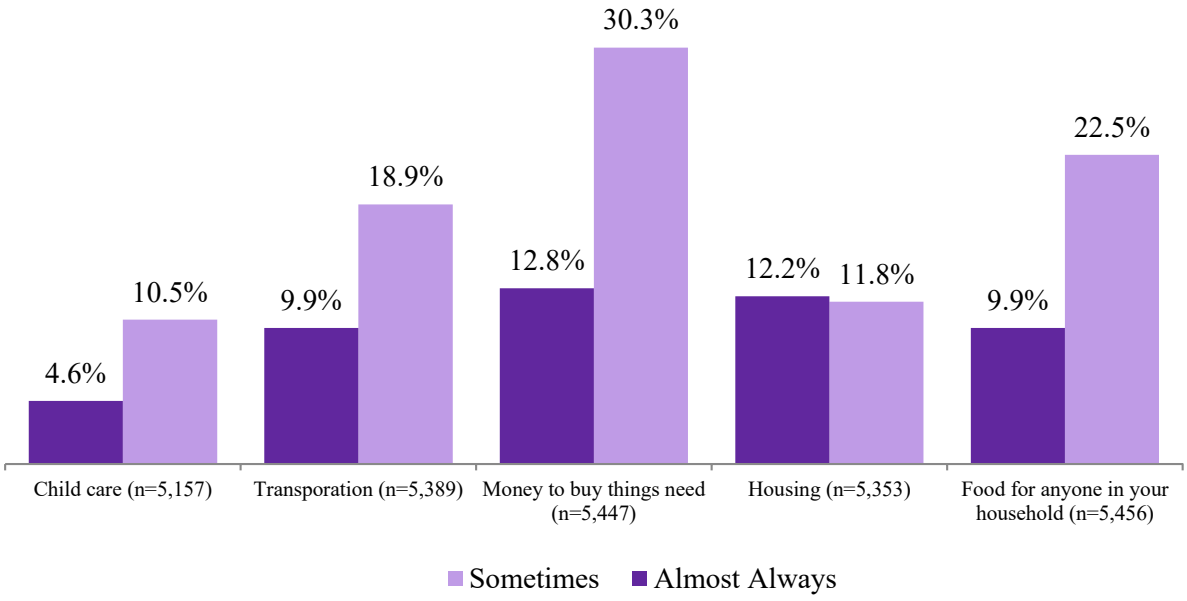


Exhibit 41. Percent of members who receive public benefits (n=5,117):

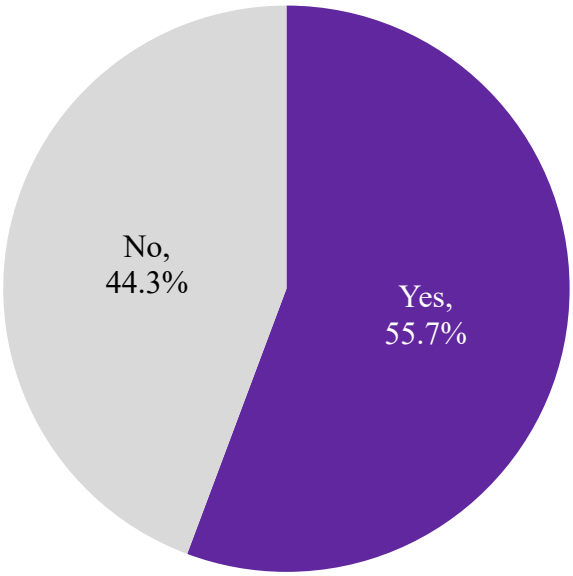
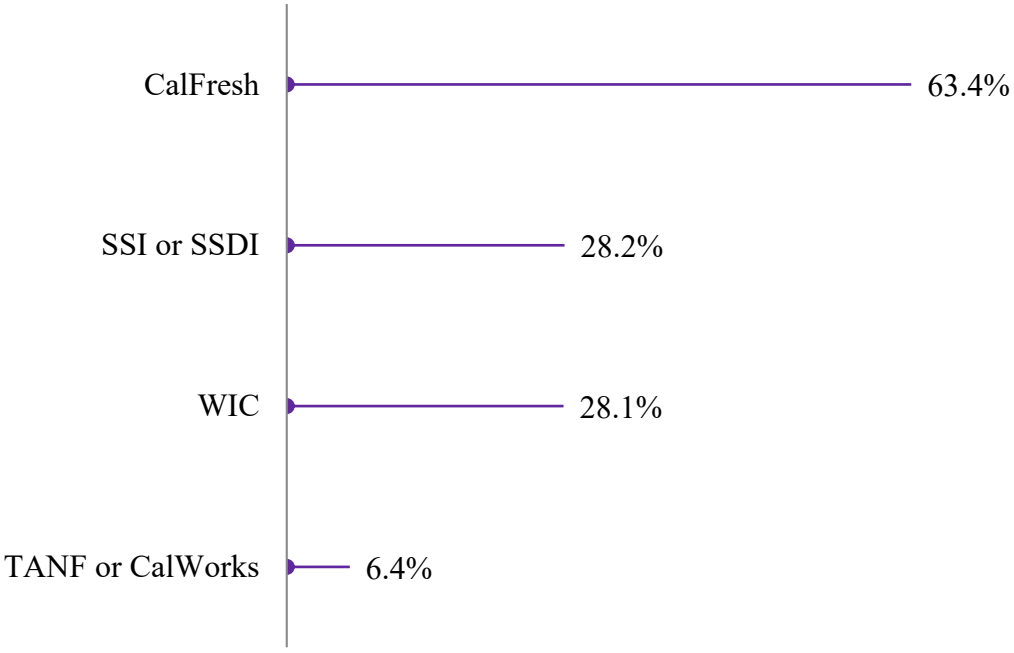


Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:

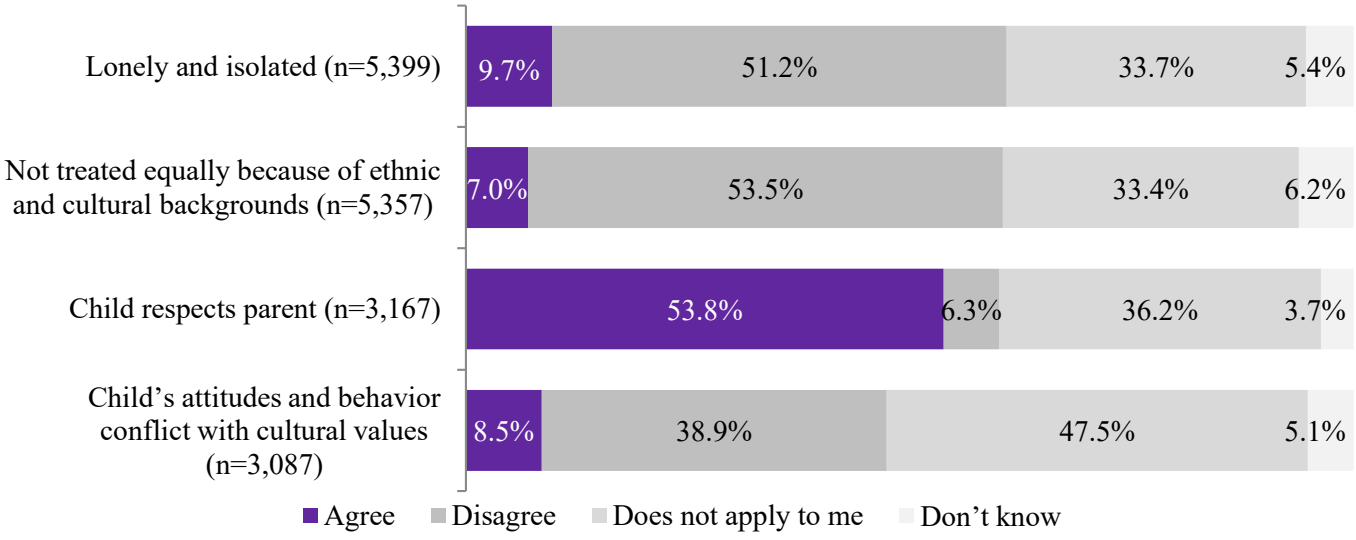


[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

Exhibit 43. Personal activities members participant in:

	Once a week	Once a month	Once in the last 6 months	Never	n
Care for a family member	36.2%	5.6%	5.1%	53.1%	5,209
Fun with others	61.9%	17.0%	6.6%	14.6%	5,396
Volunteer or Charity	16.4%	14.2%	17.3%	52.1%	5,288
Physical fitness	68.4%	10.2%	4.8%	16.7%	5,393
Attend religious centers	48.7%	11.1%	10.8%	29.4%	5,470
Get enough sleep	83.5%	5.8%	1.1%	9.6%	5,119
Enough time for self	77.4%	10.6%	3.1%	8.8%	5,209
Enough time for family	81.5%	8.5%	3.1%	6.9%	5,274
Gambling activities	0.9%	0.8%	4.8%	93.5%	5,378

Exhibit 44. Feelings towards community and home enviroment[26]:



[26] Only reported for those over 18 years old for "Child respects parent" and "Child's attitudes and behavior conflict with cultural values."

Exhibit 45. How well members speak English (n=5,549)

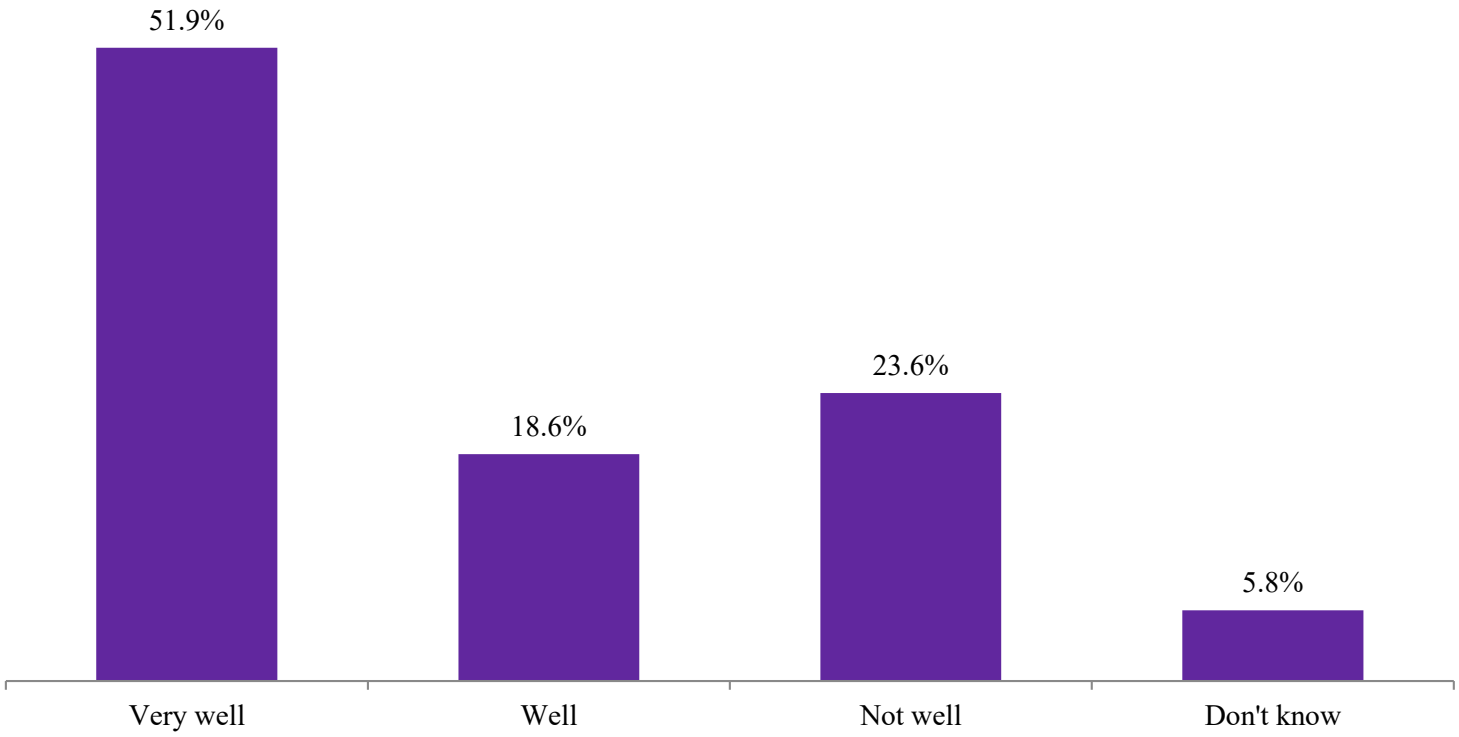


Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]

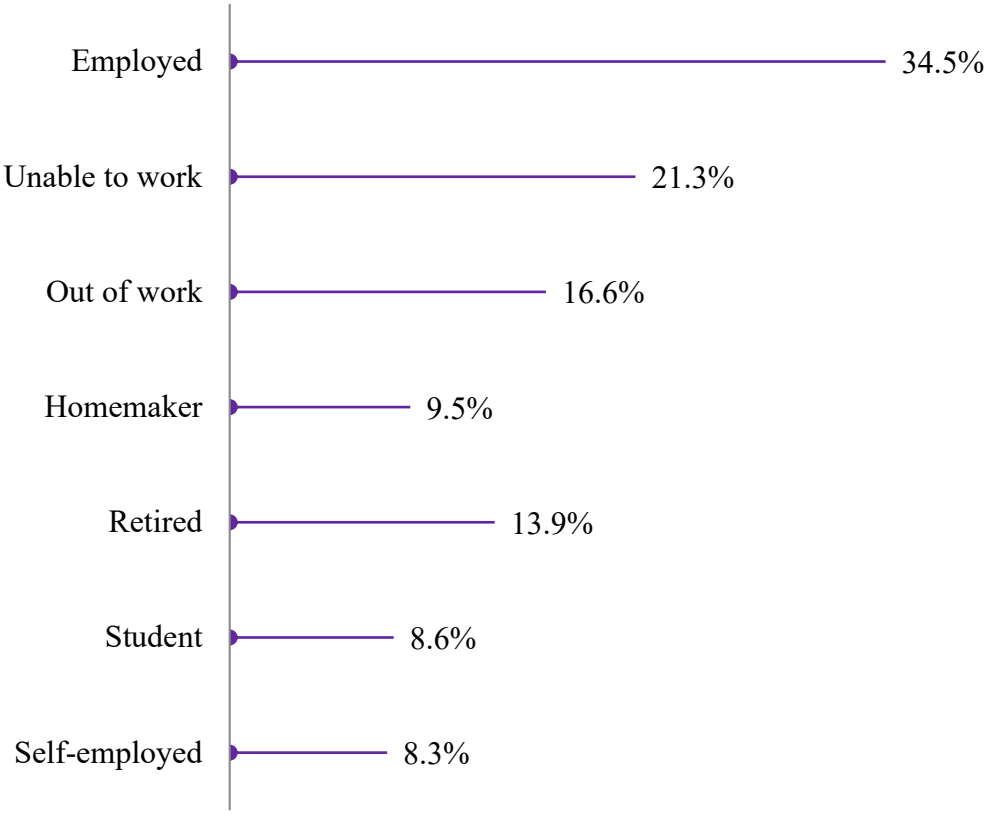
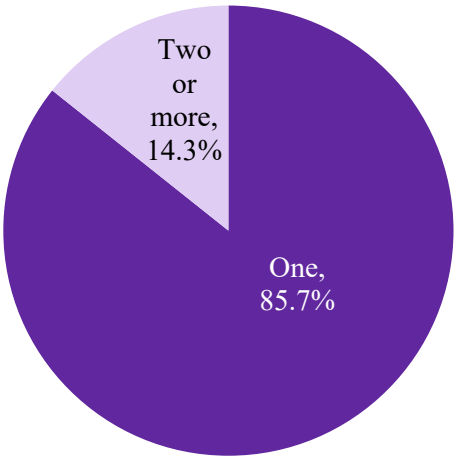
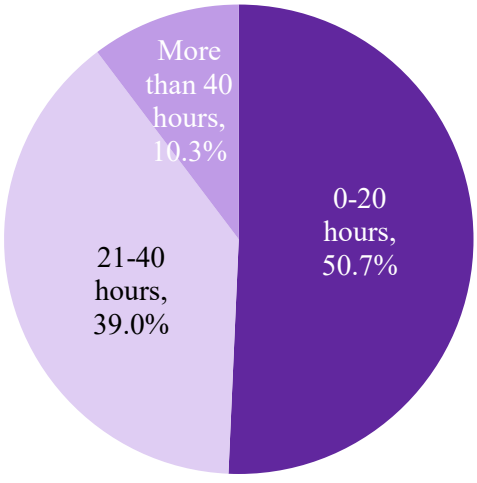


Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]

Number of jobs members have



Number of hours that members work each week



[27] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[28] Only reported the members who are over 18 years old.
[29] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

Exhibit 48. Members' living situation (n=5,590)

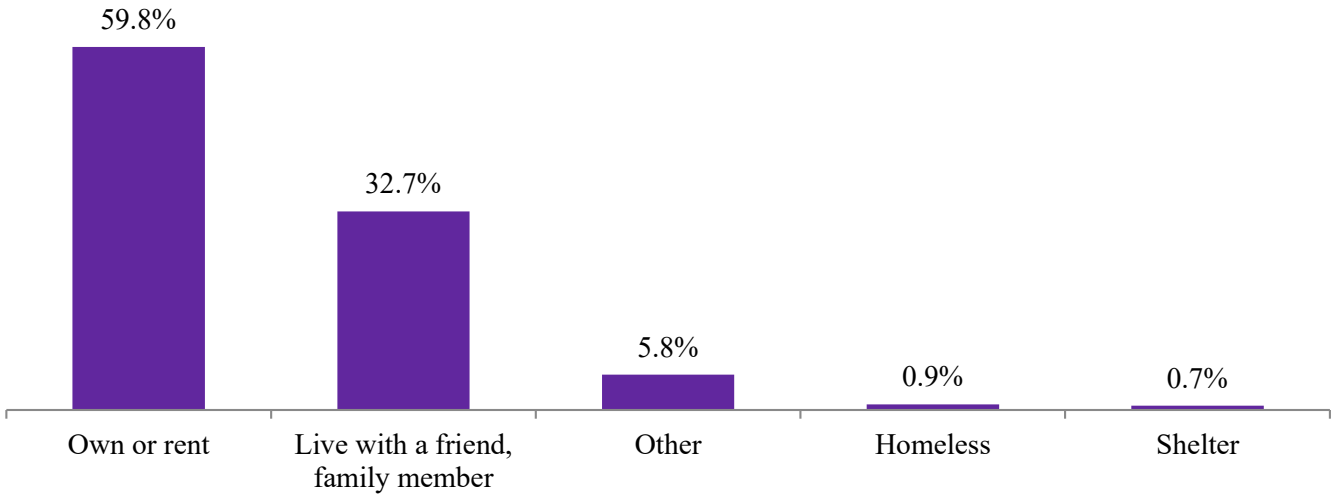
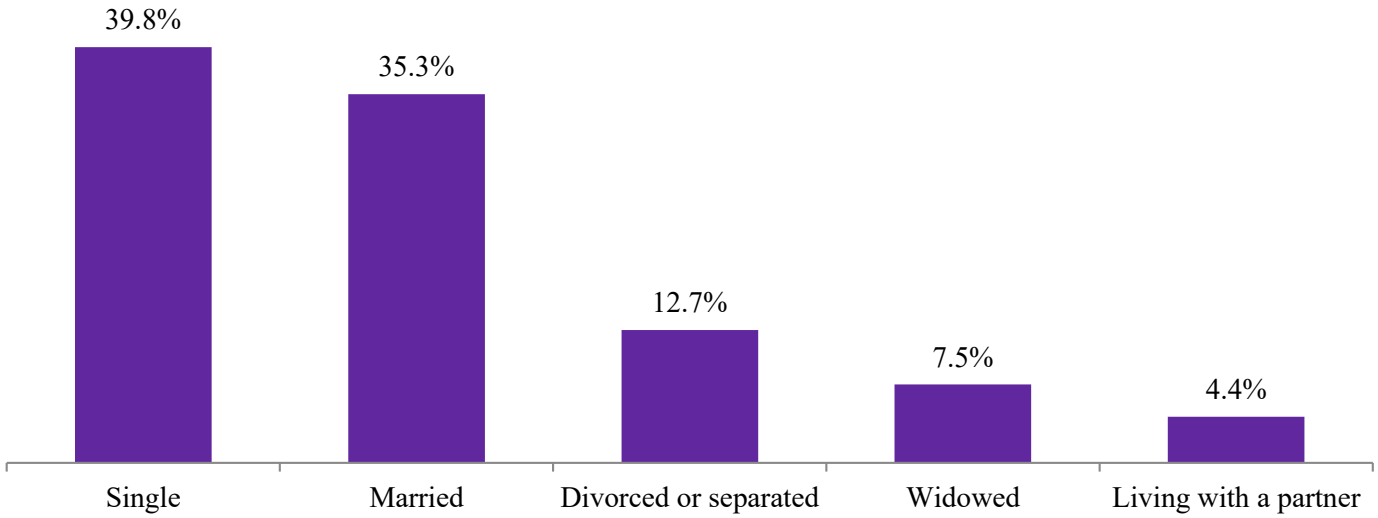


Exhibit 49. Marital status of members (n=3,271)[30]



[30] Only reported those who are over 18 years old.

Exhibit 50. Percent of members who were born in the United States (n=5,599)

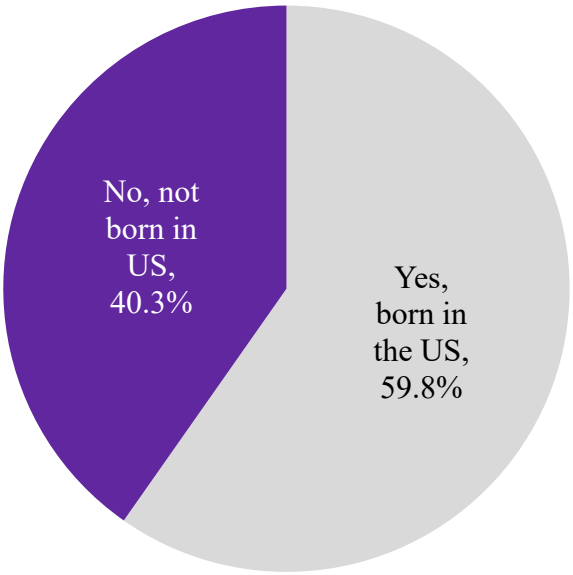
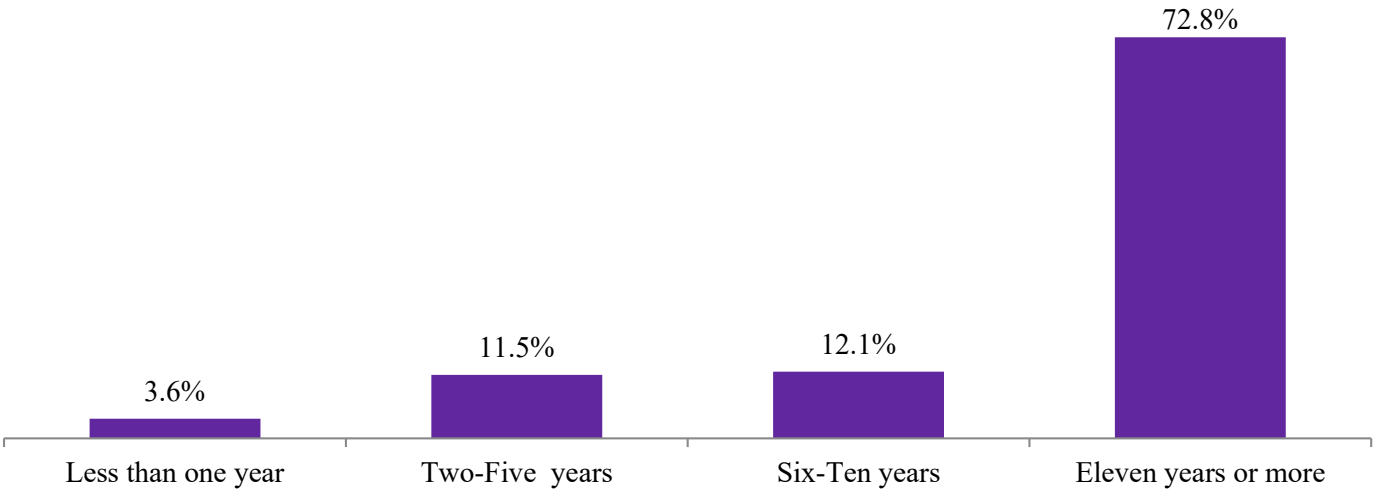


Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]



[31] Of those who were born outside of the U.S.

Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

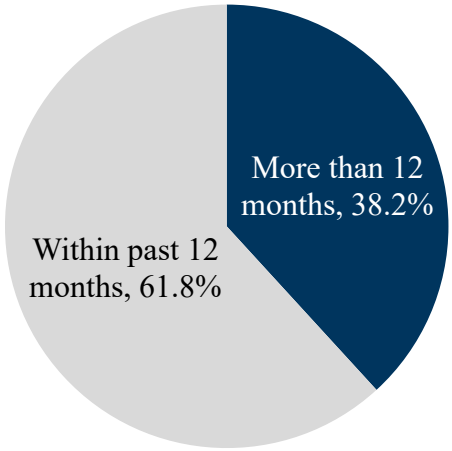
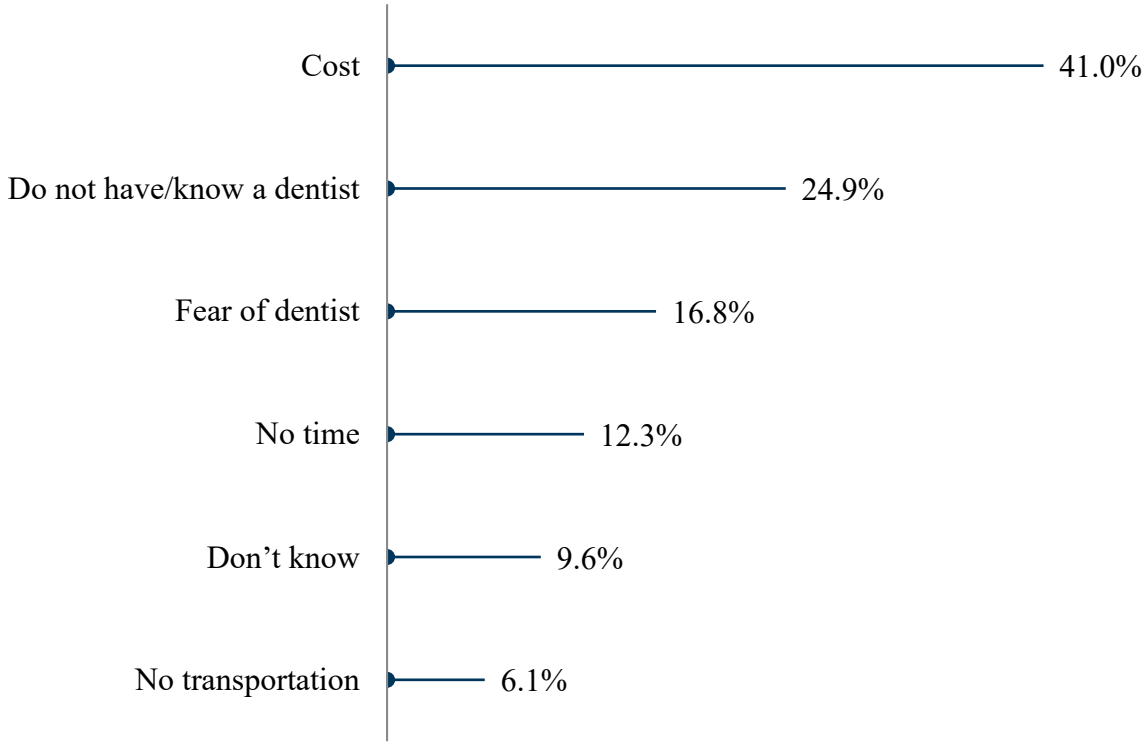
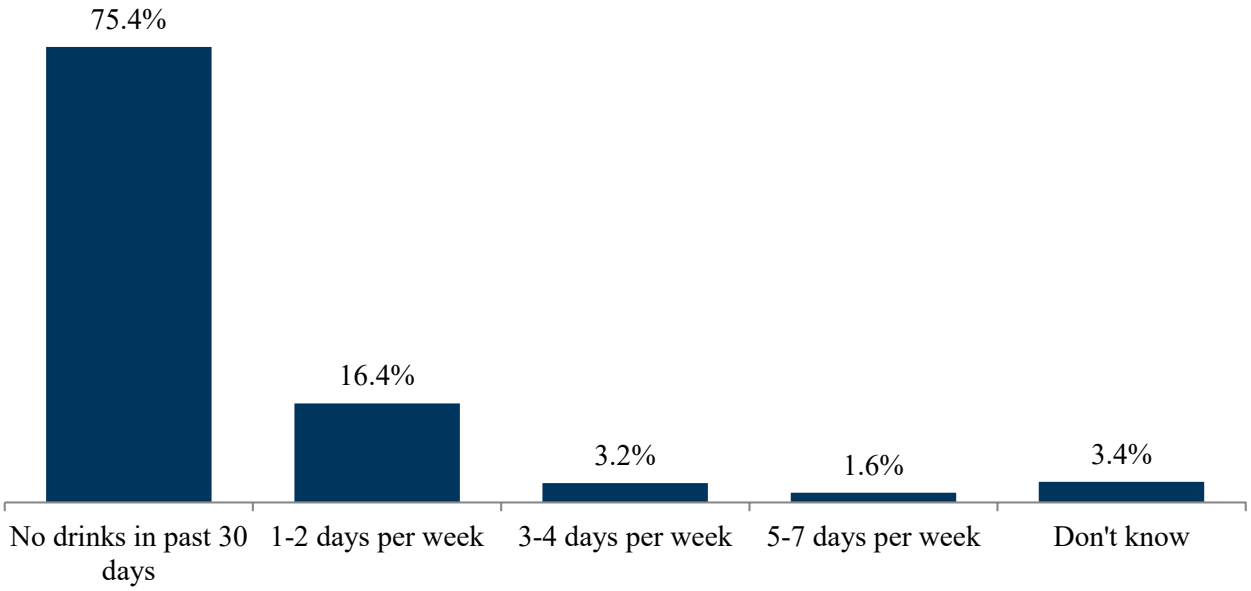


Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]



[32] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[33] Only reported those who have not seen a dentist within the past 12 months.

Exhibit 54. Days per week member had at least one drink of alcoholic beverage during the past 30 days (n=3,083)[34]



[34] Only reported those who are 18 years or older.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Cheryl Meronk, Director, Strategic Development, (714) 246-8400

Recommended Actions

1. Authorize the release of Requests for Proposal (RFPs) for community grants with staff returning at a future Board meeting with recommendations for award decisions; and
2. Authorize the reallocation of IGT 2 funds remaining from the Autism Screening project to Community Grants consistent with the state-approved IGT 2 approved funding categories.

Background

In December 2016, the CalOptima Board of Directors authorized an allocation of IGT 5 funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to address the unmet needs identified by the MHNA.

At the February 2018 Board of Directors meeting, staff presented the Executive Summary of the MHNA as well as categories of needs in the community identified by the MHNA. The Board-approved categories included:

- Adult Mental Health
- Older Adult Mental Health
- Children's Mental Health
- Nutrition Education and Physical Activity
- Children's Dental Services
- Medi-Cal Benefits Education and Outreach
- Primary Care Access and Social Determinants of Health
- Adult Dental Services

After the June 7, 2018 Board of Directors meeting, CalOptima released a notice for Requests for Information (RFI) from organizations to better define the scopes of work to address community needs in one or more of the above referenced categories. CalOptima received a total of 93 RFI responses from community-based organizations, hospitals, county agencies and other community interests. The 93 RFI responses are listed as follows:

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MHNA Categories	# of RFIs
Adult Mental Health	15
Older Adult Mental Health	13
Children's Mental Health	13
Nutrition Education and Physical Activity	12
Children's Dental Services	5
Medi-Cal Benefits Education and Outreach	10
Primary Care Access and Social Determinants of Health	19
Adult Dental Services	6
TOTAL	93

Subject matter experts and grant administrative staff performed an examination of all the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

The Ad Hoc Committee, comprised of Supervisor Do and Director DiLuigi, met on November 9, 2018 to discuss the results of the 93 RFI responses for the MHNA categories and review the staff-recommended RFPs for consideration.

Following the review of the RFI responses, the staff evaluation process and recommendations, the Ad Hoc committee recommended moving forward with the following Community Grant categories:

Community Grant Requests for Proposal (RFPs)

Grant RFP	Total Grant Award
1. Access to Children's Dental Services	$1,000,000
2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	$1,400,000
3. Access to Adult Dental Services	$1,000,000
TOTAL	**$3,400,000**

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Staff is also recommending the reallocation of an amount up to $400,000 remaining from the IGT 2 Autism Screening Project to support these community grants. This provider incentive project aimed at increasing the access to autism screenings for CalOptima children members has been discontinued. The program was able to screen a total of 110 children. Support of the grant RFPs fulfills the original Board-approved uses of the IGT 2 funds which were as follows:

1. Enhance CalOptima's core data analysis and exchange systems and management information technology infrastructure to facilitate improved coordination of care for Medi-Cal members;
2. Continue and/or expand on services and initiatives developed with 2010-11 IGT funds;
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health integration, preventive dental services and supplies, and incentives to encourage members to participate in initial health assessment and preventive health programs.

Funding for the above grant RFPs is derived as follows:

- **$3.0 million**: Remaining from IGT 5 (following anticipated Board action related to other IGT 5 funds)
- **$0.4 million:** Reallocation from IGT 2 Autism Screening Project
- **$3.4 million:** Total available for distribution through Community Grants

Following receipt and review of the RFP responses, evaluation committees consisting of staff and other subject matter experts will evaluate the responses based on a standardized scoring matrix, and will return to the Board with recommendations and proposed funding allocations.

Fiscal Impact

Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations. The recommended action to authorize the release of the Requests for Proposal (RFPs) for community grants has no additional fiscal impact to CalOptima.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence

Gary Crockett, Chief Counsel

Attachment

PowerPoint Presentation: Community Grant RFP Recommendations

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

11/28/2018 — **Date**

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Community Grant RFP Recommendations

Board of Directors Meeting
December 6, 2018

Cheryl Meronk
Director, Strategic Development

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IGT 5 Process Summary to Date

Board authorizes Member Health Needs Assessment (MHNA) to guide expenditure of IGT5 funds

MHNA identifies categories for community grants

Board authorizes Requests for Information (RFIs) to better define the scopes of work in each of the categories

93 RFI responses lead to the identification possible Requests for Proposal (RFPs)

Board Ad Hoc committee meets to consider recommending that the full Board authorize RFPs

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IGT 5 Expenditure Process

- Subject matter experts and grant administrative staff evaluated/scored all 93 RFI responses by category
  - Evaluation committees met July 30–August 9
  - Provided recommendations on scopes of work to be developed into RFPs

- Ad Hoc Committee reviewed all 93 RFI responses
  - Recommended grant to Be Well OC for first Wellness Hub
  - 3 RFPs proposed

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Grant Funding

- **$14.4M** CalOptima's share of IGT 5
- **-$11.4M** Recommended grant to Be Well OC for first Wellness Hub
- **$ 3.0M** Remaining for recommended distribution for Community Grants
- **$ 400K** Re-allocation from IGT 2 Autism Screening Project
- **$ 3.4M** **Total Available for Community Grants**

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Three Recommended Grant RFPs

RFP #	RFP Description	Funding Amount
1	Access to Children's Dental Services	$1 million
2	Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	$1.4 million
3	Adult Dental Services	$1 million
	Total	**$3.4 million**

* Multiple awardees may be selected per RFP

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RFP 1

Access to Children's Dental Services and Outreach

- **Funding Amount:** $1 million
- **Description:**
  - Provide mobile dental outreach at schools with preventative, restorative treatment/services as well as outreach and education for examinations, screenings, resources, etc.
  - Assist children/families with establishing a dental home close to their home for emergency and regular dental care
  - Provide or partner with other community dental providers to ensure patients receive restorative and other specialty dental services in addition to exams and screenings as needed

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RFP 2

Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)

- **Funding Amount:** $1.4 million
- **Description:**
  - Establish and/or operate school-based wellness centers where family, staff and community partners collaborate to align resources
  - Partner with health clinics that allow for school referrals and follow-up care
  - Provide health assessment/screenings on school campuses and community-based education for families

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RFP 3

Adult Dental Services and Outreach

- **Funding Amount:** $1 million
- **Description:**
  - Expand availability of dental services/treatment at health centers and/or mobile units with medical care integration for comprehensive health care
  - Ensure provider/staff capacity to perform assessment and restorative dental services
  - Expand dental services to nontraditional evening and weekend hours
  - Establish collaboration with community clinics/resources for specialized dental care

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Next Steps*

Mid-December 2018: CalOptima releases Community Grant RFPs, if approved

January 2019: RFP responses due

March 2019: Ad Hoc reviews recommended grant awards

April 2019: Board considers approval of grant awards

April 2019: grant agreements executed

* Dates are subject to change based on Board approval

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CalOptima A Public Agency Better. Together.

RFP 1. Access to Children's Dental Service				
Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
AltaMed Health Services Corporation	$ 156,064	Expansion of Portable Oral Health Services and Tele-dentistry in Orange County	Expand access to portable Oral Health Unit services through addition of a Dental Hygienist and introduce a tele-dentistry component into the program.	600
Coalition of Orange County Community Health Centers	$ 1,000,000	Mouths Matter: Establishing a Dental Home for All Children	Provide a dental home with a mobile dental unit equipped to provide pediatric preventive and restorative treatment, thereby completing the circle of dental care. This project will enable five federally qualified health centers (FQHC) and FQHC Look-Alikes to establish a dental home with regular and emergency care for children and families	9,000
Healthy Smiles for Kids of Orange County	$ 1,000,000	Full Cycle Dentistry	Provide preventive (screenings, dental cleanings, fluoride, sealants) and restorative treatment (fillings and cavity treatment) to CalOptima children at schools, primary care clinics, and community sites. Children who require advanced restorative treatment (such as treatment under general anesthesia) will be referred to traditional clinics in Garden Grove and CHOC Children's Hospital.	13,564
Kha Dang Le Dental Corporation	$ 1,000,000	Community Dental Care Access for Children	Educate members on optimal dental health by creating a strong traditional and social media presence. Provide exams and screenings to students in a mobile dental vehicle.	1,000

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Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Vista Community Clinic	$ 251,432	Development of a Mobile Dental Care Program for Children in North Orange County	Develop a mobile dental care program in conjunction with the school districts and schools to do full dental exams, take x-rays, place sealants, and address problems such as dental caries.	1,310

RFP 2. Primary Care Services & Social Determinats of Health

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
CHOC Children's	$ 1,396,813	The School-based Student Wellness Center: Addressing the Social Determinants of Health Where Children Are	Create three School-based Student Wellness Centers within three Orange County school districts and enhance current mental health OC Department of Education (OCDE) offerings with novel physical health and social determinant services led by a school site Coordinator and staffed by medical, nutrition, fitness, and social services personnel.	3,886
Coalition of Orange County Community Health Centers	$ 1,400,000	Healthy Kids, Healthy Schools	Collaborate with five schools in establishing school-based wellness centers throughout Orange County. These wellness centers will provide immunizations, health screenings, health education, and direct comprehensive health care (medical, dental, vision, and behavioral health) with community clinics. Six letters of support from schools/school districts were submitted.	5,500

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Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
NAMI Orange County	$ 174,794	Decreasing Stigma Through Mental Health Education, While Increasing Access to Wellness Resources	NAMI-OC will host Ending the Silence (ETS) presentations and conduct outreach at schools to further educate and increase awareness surrounding mental health conditions. Resource Navigation services will also be offered for students and their families.	13,590
Santa Ana Unified School District	$ 1,400,000	Family and Community Engagement (FACE) Wellness Centers	Enhance the Family and Community Engagement (FACE) Wellness Centers at all 57 K-12 school sites across the school district. Service providers, healthcare professionals, and local clinics will conduct services within the centers which are located within walking distance from the homes of families and residents of the entire Santa Ana community. SAUSD collaborates with local stakeholders; business organizations, institutions of higher learning, for-profit and nonprofit organizations in order to provide wrap-around services for students, families and the surrounding community. Several agreements have already been established with service providers to partner with the SAUSD.	50,000

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Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Serving Kids Hope	$ 1,351,412	School-Based Wellness Program	The project formalizes district-wide wellness assessment based on State Wellness Standards, establishing baseline and measurement of impact. It will be data-driven, with district-wide wellness assessment, documented services, and analysis and reporting of outcomes. Two letters of support from school districts were submitted.	25,975
Wellness & Prevention Center	$ 224,631	Expansion and Integration of South Orange County School-Based Wellness Centers into the CalOptima Primary Care Network	Expand five school-based wellness centers and leverage existing agreement with the Capistrano United School District. Project will increase bilingual staff, expand parental engagement, and create educational materials.	300
RFP 3. Access to Adult Dental Service				
Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
AltaMed Health Services Corporation	$ 150,678	Expanded Access to Adult Dental Services in Orange County	Expand access through the addition of a dental team in the Santa Ana clinic location and expand service hours (evening and weekend). The project also: increases awareness about coverage; promotes timely treatment plan completion; links members to a dental home; and integrates culturally-responsive, language-appropriate dental and medical services.	300

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Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Camino Health Center	$ 50,000	Adult Dental Services Expansion	Camino Health Center will be using funds to provide additional evening and weekend hours in the current dental clinic. The additional hours will allow more patients in the community access to receive dental services with hours that may be more compatible to their personal schedules. The additional funding for elective dental procedures with lab fees will allow patients to have access to procedures not covered by insurances.	150
Families Together of Orange County	$ 1,000,000	Bridging the Gap: Addressing Orange County's Oral Health Needs	Open a new health center with four dental exam rooms located on the border of Garden Grove and Anaheim, targeting patients who speak Arabic, Spanish, or Vietnamese. Dental care will be integrated into FTOC's comprehensive primary care services with evening and weekend hours.	6,000
KCS Health Center (Korean Community Services)	$ 987,600	Integration of MECCA Community Based Organizations with FQHC Adult Oral Care Access in Mobile and Nontraditional Delivery Modalities	KCS Health Center requests to build mobile sites at each of its six (6) partnering MECCA community-based organizations and extend hours of operation to nontraditional hours at the mobile sites as well as at KCS Health Center and Southland Integrated Services locations. The organizations together serve populations that speak Spanish, Vietnamese, Korean, Farsi, Arabic, and Khmer	8,000

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Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Kha Dang Le Dental Corporation	$ 1,000,000	Community Dental Care Access for Adults	Educate members on optimal dental health by creating a strong traditional and social media presence. Add an additional day (on Fridays) for 9 hours to provide more access to care and allow more appointments.	1,000
Livingstone Community Development Corporation	$ 350,000	Finding Your Smile: Expanding Dental Services for Adults Beyond Emergency Care	Expand direct preventive and restorative dental services by increasing dental program staff, extending hours and days of operation and providing improved integration with its primary care program. The dental program will provide exams and x-rays, dental cleaning, cavity fillings, extractions, root canal treatments, and crowns.	2,500
Serve the People	$ 1,000,000	Oral Health for the Homeless	Establish dental care access points with a three-chair dental mobile unit at 10 homeless shelters managed by homeless support service providers. These new dental homes will provide preventative, restorative, and specialized dental care to CalOptima members.	1,500
St. Jeanne de Lestonnac Free Clinic	$ 180,000	Oral Health Program	Increase outreach efforts and purchase equipment and supplies to treat more patients. Dental services include exams, x-rays, fillings, root canals, and tooth extractions. Lab work and/or dental prosthetics will be available to patients at cost with no additional markup.	100

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Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Vista Community Clinic	$ 251,432	Development of a Mobile Dental Care Program for Adults in North Orange County	Develop a mobile dental care program serving adults in La Habra to do full dental exams, x-rays, sealants, and addressing problems such as dental caries. The program will be include an outreach initiative, to helping to raise awareness of safety-net healthcare services, and promoting knowledge of and access to CalOptima's health care services.	1,426

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GRANT REPORT TEMPLATE

GRANTEE INFORMATION

Name of Organization/Tax ID:	Healthy Smiles for Kids of Orange County XX-XXXXXXX
Address:	2101 E. Fourth St., Suite 220A, Santa Ana, CA 92705
Phone Number:	714-537-0700
Contact Name:	Tommie Servi (Ext. 7938) or 714-309-7485
Email:	tservi@healthysmilesoc.org
Is your 501(c)3 status current?	Yes ☒ No ☐ Not Applicable ☐
If no, explain	
Executive Director Name:	Ria Berger
Board Chair Name:	Richard Lee
Chief Financial Officer:	Kim Banco

GRANT INFORMATION

RFP 15-026 Orange County Public School-based Dental Services Grant	
Proposal Title: "Prevention Oral Health for School Aged Children"	

GRANT REPORT INFORMATION

Type of Grant Report

Annual Progress ☐ Final ☒

Report Due Date:	7/1/2017
Report Submission Date:	6/30/2017

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EVALUATION CHART-FOR PROGRESS & FINAL REPORTS

Instructions: Please Submit an Updated Evaluation Chart with "Actuals" tied to Scope of Work in Attachment A

Objectives	Activities	Evaluation Indicators	Timeline
Establish site of dental care at high-need school	Yr 1 was focused on expansion. Healthy Smiles exceeded goals by doubling the number of schools visited; 5 new school districts and 56 new school sites were added; Yr 2 the focus was on improving participation rates in addition to continued expansion efforts. This was achieved by reviewing participation rates of schools in Yr 1 to exclude some of the low volume schools from our current year schedule and creation of a School Relations Coordinator position to work more closely with school staff to increase their engagement, get parent advocates involved and take advantage of communication options within the school system, such as email blasts, school newsletters, announcements at school events, banners in front of the school, etc. The average participation rate in Yr 1 was 23.7%. The participation rate for Yr 2 is 31.7%. Average for two years is 27.7%.	1. MOU's signed for five new school districts. 2. 16 new schools listed in Attachment G 3. 40 new schools not listed on Attachment G 4. 56 total new schools screened 5. Screenings from Expansion into New Schools: 7,468 6. Participation Rate: 27.7%	Jun 2015 – May 2017
Render oral health services and screening to 10,000-12,000 per year students at high-need	We are defining events as each day the mobile unit is at the school – one for each screening day and one for each sealant day depending on number of children to be seen and scheduling. We are collecting data on all schools	1. # of school events: 525 2. # of schools visited: 180 3. Children educated: 98,202	Jun 2015 – May 2017

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schools	screened within the year though some related services may fall outside of the year (education/care coordination).	4. Parents/Teachers Educated: 4,694 5. Screenings: 29,753 6. Fluoride: 27,018 (90.8%) 7. Children Receiving Sealants: 10,470 (35.2%) 8. # of Sealants Applied: 31,698 9. # of children screened with visible decay: 16,125 or 54.2% 10. # of children screened with severe decay: 3.028 or 10.2%	
Connect children to a usual source of dental care	We have seen the number of children needing referral to a dental home decreasing due to increased dental insurance coverage for children and more families are connected to a dental provider. There are also a percentage of cases where we are unable to connect with the parent or they decline assistance.	1. % of children with visible decay who were linked to a dental home: 39% 2. % of children with visible decay who received referral for restorative care: 5.9%	Jun 2015 – May 2017
Track participation rates at schools and service utilization to inform CalOptima	In order to determine whether children identified as needing care have received treatment or completed treatment, care coordinators will need to contact parents subsequent to screening and may require more than one follow up call. Due to this, these numbers will take additional time to accumulate. There are also cases	1. % of parents who did not submit a consent form for their child's participation in the screening event: 72.5%	Jun 2015 – May 2017

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	where care coordinators are unable to connect with the parent or the parent is uncooperative. As a result, we may not be able to identify all patients not receiving or completing treatment. This does not mean they are not getting treatment. Yr 2 %'s are provided but they will not include all outcomes from schools visited in the last quarter or from those parents that we were unable to contact or who refused to speak with us. Since there is a significant time lag in gathering this information, it will not be complete for reporting on quarterly reports. Note that 33.2% of parents declined care coordination. Of those who did not decline HSK care coordination, 29.2% HSK was unable to make a connection and 2.3% refused assistance.	2. % of children who did not ***receive*** treatment after being identified as needing care: In Yr 2 – 19.7% could be confirmed as receiving treatment (note this is based on the number of children whose parents accepted care coordination) 3. % of children who did not ***complete*** treatment after being identified as needing care: In Yr 2 – 14.6% could be confirmed as completing treatment (note this is based on the number of children whose parents accepted care coordination)	

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QUESTIONAIRE TRACKING DATA- FOR ALL REPORTS	
1. Total number of events	525
2. Number of participating schools	180
3. For each school where services are rendered, please provide the following information: a) Name and address of the school b) Main contact person at the school who can verify that services were rendered c) Total number of students enrolled at the school and the percentage of students who received dental services d) Age range of children served (e.g. 5-11 years) at each school e) Number and percentage of children served who had visible decay f) Number of referrals for restorative care	See attached spreadsheet

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FOR ANNUAL PROGRESS REPORTS (Due on annual basis)	YOUR ANSWERS
1. Please describe progress towards the performance target/milestones being reported on. If progress was not made, please describe why.	HSK exceeded targets in all areas.
2. Have you made any deviations from your original proposal? Explain how these deviations have, or will impact the project.	No, focus is the same. Addition of new FQHC allowed us to serve more schools.
3. Have you encountered any unexpected successes or challenges during this reporting period?	Have signed new FQHC contracts that will allow us to continue to expand services.
4. Are you requesting any changes to the project workplan or grant outcome? Please explain.	No
FOR FINAL REPORT (Due 30 days after completion of contract)	**YOUR ANSWERS**
1. Were you able to meet the desired outcomes of this grant? Please explain.	Yes, have exceeded goals.
2. What were the key variables contributing to your success or failure?	Strong relationships with FQHC's and school districts.
3. Please describe any unexpected successes or challenges you have experienced as a result of the grant. How have these items impacted the project and/or organization?	The grant allowed us to significantly expand. The first year of the grant, HSK doubled the number of schools served.
4. Please list any organizational or programmatic changes that will be made as a result of the grant experience.	HSK was able to implement processes that allow us to serve more schools each year. Our success will allow us to attract new school districts and FQHC partners.

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5. Do you have any additional information about your project or the grant experience you would like to share with CalOptima?	We appreciate the support from CalOptima. For HSK, it's all about the kids. We were able to serve so many more children as a result of CalOptima support.

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FINANCIALS-FOR ANNUAL PROGRESS AND FINAL REPORTS			
COLUMN 1- PROJECTED EXPENSES	COLUMN 2- ACTUAL EXPENSES	COLUMN 3- DIFFERENCES BETWEEN PROJECTED AND ACTUAL EXPENSES	COLUMN 4- EXPLANATION OF DIFFERENCES
241,438	241,438	-0-	Staffing – hired additional staff due to change in program structure and to provide coverage for increase in services
96,668	96,668	-0-	Supplies – mobile unit expenses are higher due to unanticipated repairs. Dental supplies higher due to servicing more children than anticipated.
47,542	47,542	-0-	Facilities, Telephone, IT – lower allocation of space for Prevention team due to expansion of other programs that are picking up a larger portion
14,352	14,352	-0-	Other expenses – printing costs less than expected due to implementation of scanning processes. Cushion built into this category was not utilized.
400,000	400,000	-0-	Totals

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QUESTIONS	ANSWERS
1. List the organization names and grant amounts of all sub-grantees and/or consultants indirectly receiving Foundation funds from this grant.	NA

***NOTE**-Please note that if there are any remaining funds from the grant, CalOptima will require you to document an appropriate use regarding how you intend to spend the funds.*

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I hereby certify that this report, including any attachments, is accurate to the best of my knowledge, and that our organization, remains in full compliance with the terms of the Grant Contract. (Signatures are required for each position listed below)	
Primary Contact for Project	
Name:	Tommie Servi
Title:	Vice President of Operations
Signature:	Tommie Servi
Date:	June 30, 2017
Executive Director or Board Chair	
Name:	Ria Berger
Title:	Chief Executive Officer
Signature:	Ria Berger
Date:	June 30, 2017
Chief Financial Officer	
Name:	Kim Banco
Title:	Vice President of Finance
Signature:	
Date:	June 30, 2017

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CALOPTIMA TRACKING DATA - Final Years 1 & 2

Healthy Smiles for Kids of Orange County - RFP 15-026

1. Total number of events: 525

2. Number of participating schools: 89

NM	Newport Mesa
OV	Oceanview
SA	Santa Ana
SV	Savanna
TU	Tustin
WE	Westminster

*Includes parents and teachers

SCREENING DATE	SCHOOL DISTRICT	EVENTS	SCHOOL	ADDRESS	CITY/STATE	POSTAL CODE	CURRENT(CUR)/TARGET(TAR) /NEW(NEW)	SCHOOL POPULATION	CHILDREN SCREENED	EXPANSION	FLUORIDE	CHILDREN RECEIVING SEALANTS	# OF SEALANTS APPLIED	% WHO RECEIVED SERVICES	AGE RANGE	NUMBER OF CHILDREN WITH VISIBLE DECAY	% OF CHILDREN SERVED WITH VISIBLE DECAY	# OF CHILDREN WITH SEVERE DECAY (EMERGENCY)	ORAL HEALTH EDUCATION PROVIDED *	DECLINED CARE COORDINATION	LINKED TO DENTAL HOME	NUMBER OF REFERRALS FOR RESTORATIVE CARE	NOT CONNECTED	IN TREATMENT	TREATMENT COMPLETED	UNABLE TO CONFIRM TREATMENT	REFUSED TREATMENT
4/28/2016	NM	3	Adams Elementary	2850 Clubhouse Rd.	Costa Mesa, CA	92626	NEW	427	155	155	139	61	196	36.3%	5-12	74	47.7%	11	456	57	2		1				
1/25/2016	GG	2	Anthony Elementary	15320 Pickford St.	Westminister, CA	92683	NEW	467	146	146	134	51	167	42.7%	5-12	68	46.6%	19	490	39	32	3	15	3	14	8	1
11/9/2015	CY	2	Arnold Elementary	9281 Denni St.	Cypress, CA	90630	TAR	748	91	91	83	31	114	12.2%	5-12	34	37.4%	1	764	35	18	2	6	2	7	3	
2/25/2016	MA	2	Baden-Powell Elementary	2911 W. Stonybrook Dr.	Anaheim, CA	92804	NEW	734	60	60	53	25	61	8.2%	5-12	32	53.3%	8	708	24	11	2	11	1	3	1	2
12/14/2015	TU	3	Benson Elementary	12712 Elizabeth Way	Tustin, CA	92780	TAR	353	41	41	37	7	27	11.6%	5-12	20	48.8%	0	369	13	10	1	3		6		
11/3/2015	TU	4	Beswick Elementary	1362 Mitchell Ave.	Tustin, CA	92780	TAR	683	286	286	239	72	248	41.9%	5-12	139	48.6%	27	660	96	75	14	27	10	30	13	
4/4/2016	GG	3	Brookhurst Elementary	9821 Catherine Ave.	Garden Grove, CA	92841	CUR	514	180		165	69	289	35.0%	5-12	83	46.1%	15	532	66	43	2	15	3	3		2
2/29/2016	GG	2	Bryant Elementary	8371 Orangewood	Garden Grove, CA	92841	CUR	760	166		155	85	218	21.8%	5-12	99	59.6%	18	770	70	60	13	31	9	10	23	
10/5/2015	CE	2	Buena Terra Elementary	8299 Holder St.	Buena Park, CA	90620	CUR	508	70		65	27	100	13.8%	5-12	33	47.1%	5	542	30	16	4	5	1	7	4	1
9/24/2015	CE	3	Centralia Elementary	195 N. Western Ave.	Anaheim, CA	92801	CUR	582	170		157	60	139	29.2%	5-12	116	68.2%	5	561	61	51	7	31	3	21	18	
2/18/2016	SV	2	Cerritos Elementary	3731 Cerritos	Anaheim, CA	92804	NEW	502	67	67	62	31	81	13.3%	5-12	32	47.8%	8	550	18	20	3	5	3	9	5	
12/1/2015	GG	1	Clinton Corner Pre-School	13581 Clinton St.	Garden Grove, CA	92843	CUR	240	135		118	0	0	56.3%	3-5	74	54.8%	9	259	29	36	7	26	3	14		
3/29/2016	GG	2	Clinton Elementary	13641 Clinton St.	Garden Grove, CA	92843	NEW	695	171	171	133	49	187	24.6%	5-12	67	39.2%	9	718	64	20	2	28		2		2
10/13/2015	GG	2	Cook Elementary	9802 Woodbury Ave.	Garden Grove, CA	92844	CUR	389	89		83	38	128	22.9%	5-12	37	41.6%	3	369	32	17	3	9		8	5	1
8/25/2015	CE	3	Danbrook Elementary	320 Danbrook St.	Anaheim, CA	92804	CUR	672	262		235	45	155	39.0%	5-12	138	52.7%	10	662	101	69	14	31	21	33	13	
1/11/2016	SA	1	Davis Elementary	1405 French St	Santa Ana, CA	92701	CUR	747	140		127	42	133	18.7%	5-12	89	63.6%	15	680	42	53	7	16	9	18	6	3
&	SA	2	Diamond Elementary	1450 S. Center St.	Santa Ana, CA	92704	CUR	600	311		277	131	381	51.8%	5-12	179	57.6%	71	598	48	85	23	36	14	30	13	1
4/26/2016	MA	2	Disney Elementary	2323 W. Orange Ave.	Anaheim, CA	92804	NEW	671	147	147	130	51	180	21.9%	5-12	67	45.6%	9	705	72	1		1		1		1
9/15/2015	CE	2	Dysinger Elementary	7770 Camellia Dr.	Buena Park, CA	90620	CUR	534	97		94	32	111	18.2%	5-12	34	35.1%	5	531	38	12	4	10	1	3	5	
&	AN	4	Edison Elementary	1526 E. Romneya	Anaheim, CA	92805	CUR	1002	219		200	81	246	21.9%	5-12	94	42.9%	9	928	90	55	12	19	11	25	8	4
6/2/2015	SA	3	El Sol Elementary	1010 N. Broadway St.	Santa Ana, CA	92701	CUR	800	175		162	57	203	21.9%	5-12	68	38.9%	10	591	79	28	9	11		15	3	
12/15/2016	TU	2	Estock Elementary	14741 North B Street	Tustin, CA	92780	TAR	384	92	92	81	28	97	24.0%	5-12	54	58.7%	9	389	32	27	9	11		5		
6/1/2015	GG	3	Faylane Elementary	11731 Morrie Ln.	Garden Grove, CA	92840	CUR	628	83		79	50	184	13.2%	5-12	47	56.6%	8	488	22		1					
3/22/2016	GG	2	Faylane Elementary	11731 Morrie Ln.	Garden Grove, CA	92840	CUR	610	121		113	44	163	19.8%	5-12	57	47.1%	12	479	34	29	4	14	5	6		
11/17/2015	TU	2	Foss Elementary	18492 Vanderlip Ave.	Santa Ana, CA	92705	NEW	452	43	43	41	17	57	9.5%	5-12	14	32.6%	0	401	21	7	2	1		1	1	
10/19/2015	AN	3	Franklin Elementary (Anaheim)	521 W. Water St.	Anaheim, CA	92805	CUR	879	128		122	49	172	14.6%	5-12	65	50.8%	11	895	49	29	4	16	3	16	8	1
10/20/15	SA	5	Franklin Elementary (Santa Ana	210 W. Cubbon St.	Santa Ana, CA	92701	CUR	489	193		176	60	245	39.5%	5-12	110	57.0%	11	469	67	48	9	24	9	14	11	2
3/10/2016	GG	2	Gilbert Elementary	9551 Orangewood Ave.	Garden Grove, CA	92841	NEW	530	96	96	89	38	106	18.1%	5-12	60	62.5%	6	539	25	27	3	19	3	2		
2/1/2016	SV	2	Hansen Elementary	1300 South Knott	Anaheim, CA	92804	NEW	690	126	126	117	51	155	18.3%	5-12	60	47.6%	9	719	46	23	5	15	3	3	9	
4/14/2016	SA	3	Harvey Elementary	1635 S. Center St.	Santa Ana, CA	92704	CUR	447	168		147	81	220	37.6%	5-12	79	47.0%	20	479	61	41	9	14	3	1		1
10/12/2015	GG	3	Hazard Elementary	4218 West Hazard Ave.	Santa Ana, Ca	92703	NEW	630	153	153	140	50	217	24.3%	5-12	64	41.8%	8	630	40	36	9	21	3			1
1/19/2016	TU	3	Heideman Elementary	15571 William St	Tustin, CA	92780	TAR	630	214	214	192	89	311	34.0%	5-12	107	50.0%	14	655	64	55	12	22	9	28	7	
10/27/2015	GG	3	Heritage Elementary	426 S. Andres Place	Santa Ana, CA	92704	CUR	600	157		139	57	196	26.2%	5-12	63	40.1%	3	573	71	30	5	7	1	9	6	2
3/1/2016	GG	2	Hill Elementary	9681 11th St.	Garden Grove, CA	92844	NEW	370	88	88	84	39	133	23.8%	5-12	35	39.8%	10	383	22	17	3	11	3			
2/11/2016	SV	2	Holder Elementary	9550 Holder St.	Buena Park, CA	90620	NEW	560	87	87	80	31	109	19.6%	5-12	40	46.0%	6	557	33	16	4	12	1	3	7	2
6/9/2015	SA	3	Jackson Elementary	1143 S. Nakoma Dr.	Santa Ana, CA	92704	CUR	1126	154		132	48	174	13.7%	5-12	60	39.0%	5	1046	39		1	12	9	9		
11/5/2015	SA	3	Jefferson Elementary	1522 W. Adams St.	Santa Ana, CA	92704	CUR	897	147		137	51	148	16.4%	5-12	79	53.7%	30	814	43	49	13	14	3	14	12	1
11/2/2015	CY	2	King Elementary	8710 Moody St.	Cypress, CA	90630	TAR	585	65	65	62	27	100	11.1%	5-12	19	29.2%	3	584	27	7		4	1	4		1
11/13/2015	TU	3	Lambert Elementary	1151 San Juan St.	Tustin, CA	92780	TAR	523	169	169	156	65	243	32.3%	5-12	71	42.0%	8	435	55	41	10	21	4	13	14	
8/19/2015	CY	3	Landell Elementary	9739 Denni St.	Cypress, CA	90630	TAR	750	63	63	52	20	68	8.4%	5-12	29	46.0%	4	737	33	12	1	3		7	1	4
9/14/2015	CE	2	Los Coyotes Elementary	8122 Moody St.	La Palma, CA	90623	CUR	529	90		79	41	148	17.0%	5-12	34	37.8%	4	575	41	16	2	7	1	6	2	4
2/22/2016	MA	2	Low Elementary	215 N. Ventura St.	Anaheim, CA	92801	NEW	704	101	101	91	48	93	14.3%	5-12	49	48.5%	10	729	28	25		7	3	10	4	
1/21/2016	SA	5	Lowell Elementary	700 S Flower St	Satna Ana, CA	92703	CUR	900	307		292	135	342	34.1%	5-12	164	53.4%	38	947	91	82	20	32	7	33	14	3
10/26/2015	CY	2	Luther Elementary	4631 La Palma Ave.	La Palma, CA	90623	TAR	515	59	59	53	20	71	11.5%	5-12	19	32.2%	0	535	20	9	1	10		1	1	
8/3/2015	AN	3	Mann Elementary (Tracks BC)	600 W. La Palma Ave.	Anaheim, CA	92801	CUR	668	125		118	53	188	18.7%	5-12	64	51.2%	9	609	47	41	16	8	7	14	4	1
12/7/2015	GG	3	Marshall Elementary	15791 Bushard St.	Westminister, CA	92683	TAR	456	109	109	96	48	150	23.9%	5-12	58	53.2%	6	472	33	28	28	20		5		
3/15/2016	MA	2	Marshall Elementary	2627 Crescent Ave.	Anaheim, CA	92801	NEW	657	56	56	49	12	47	8.5%	5-12	35	62.5%	4	707	7	10	3	8	1	19		
10/22/2015	SA	5	Martin Elementary	939 W. Wilshire Ave.	Santa Ana, CA	92707	CUR	750	285		262	119	303	38.0%	5-12	129	45.3%	62	767	86	70	16	31	3	24	12	

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4/25/2016	MA	3	Maxwell Elementary	2613 W. Orange Ave.	Anaheim, CA	92804	NEW	802	206	206	177	70	182	25.7%	5-12	108	52.4%	12	871	63	14	2			1			
9/8/2015	CE	2	Miller Elementary	7751 Furman Rd.	La Palma, CA	90623	CUR	579	62		52	29	113	10.7%	5-12	25	40.3%	4	612	29	10	3	5	2	5	3	1
3/24/2016	GG	3	Mitchell Elementary	13451 Taft Ave.	Garden Grove, CA	92843	CUR	469	153		137	70	189	32.6%	5-12	80	52.3%	21	463	63	22	2	29		1		
11/16/2015	CY	2	Morris Elementary	9952 Graham St.	Cypress, CA	90630	TAR	737	62	62	52	18	67	8.4%	5-12	26	41.9%	4	763	24	8		8		2	2	
11/19/2015	TU	2	Nelson Elementary	14392 Browning Ave.	Tustin, CA	92780	TAR	620	60	60	52	12	29	9.7%	5-12	38	63.3%	13	649	21	17	7	8	2	6	3	
3/10/2016	GG	1	Newhope Elementary	4419 West Regent Dr.	Santa Ana, CA	92704	NEW	431	63	63	63	2	3	14.6%	5-12	33	52.4%	4	416	24	16	7	5		1		1
3/3/2016	OV	3	Oakview Elementary	17241 Oak Lane	Huntington Beach, CA	92647	CUR	709	201		182	82	193	28.3%	5-12	96	47.8%	20	689	77	41	2	16	1	1		1
11/10/2015		1	Oakview Pre-School	17241 Oak Lane	Huntington Bch, CA	92647	CUR	320	81		75	0	0	25.3%	3-5	38	46.9%	2	281	23	19	3	9	2	9	9	1
1/12/2016	GG	2	Parkview Elementary	12272 Wilken Way	Garden Grove, CA	92840	CUR	500	81		80	45	161	16.5%	5-12	35	43.2%	5	574	25	19	7	10		11		
4/12/2016	NM	2	Paularino Elementary	1060 Paularino Ave.	Costa Mesa, CA	92626	NEW	485	130	130	117	48	166	26.8%	5-12	47	36.2%	10	445	46	24	5	10	2			1
4/5/2016	GG	2	Peters Elementary K-2	13162 Newhope St.	Garden Grove, CA	92843	CUR	1180	172		164	67	211	9.7%	5-12	109	70.2%	150	1262	53	59	14	20	6	18	9	2
11/12/2015	SA	3	Pio Pico Elementary	931 W. Highland St.	Santa Ana, CA	92703	CUR	634	155		145	20	134	24.4%	5-12	85	54.8%	29	635	46	38	9	25	6	14	7	1
&8/24/2015	AN	3	Ponderosa Elementary	2135 S. Mountain View Avenue	Anaheim, CA	92802	CUR	1032	324		291	123	441	31.4%	5-12	159	49.1%	35	1041	99	84	17	60	16	40	20	4
3/17/2016	MA	3	Pyles Elementary	10411 S. Dale Ave.	Stanton, CA	90680	NEW	721	142	142	117	61	157	19.7%	5-12	71	50.0%	19	791	56	66	8	19	2	3		2
5/16/2016	NM	4	Rea Elementary	661 Hamilton St.	Costa Mesa, CA	92627	NEW	502	192	192	177	64	195	38.2%	5-12	118	61.5%	23	502	43	4						
2/2/2016	SV	3	Reid Elementary	720 S. Western Ave.	Anaheim, CA	92804	NEW	657	147	147	138	67	263	22.4%	5-12	66	44.9%	17	706	49	35	3	13	1	11	11	2
6/8/2015	SA	4	Remington Elementary	1325 E. Fourth St.	Santa Ana, CA	92701	TAR	339	87	87	83	72	247	25.7%	5-12	36	41.4%	5	331	30	32	3					
11/30/2015	SA	2	Remington Elementary	1325 E. Fourth St.	Santa Ana, CA	92701	CUR	319	69	69	64	22	76	21.6%	5-12	43	62.3%	9	363	9	28	2	13	6	10	12	
5/3/2016	AN	5	Revere Elementary	140 W. Guinida Lane	Anaheim, CA	92805	CUR	921	314		285	130	480	34.1%	5-12	181	57.6%	21	955	118	5	1					
5/10/2016	GG	3	Riverdale Elementary	13222 Lewis St.	Garden Grove, CA	92843	CUR	553	164		158	65	227	29.7%	5-12	72	43.9%	13	585	57	2						
2/23/2016	GG	3	Rosita Elementary	4726 Hazard Ave.	Santa Ana, CA	92703	CUR	569	184		173	76	204	32.3%	5-12	89	48.4%	15	535	67	48	4	15	6	13	16	2
4/21/2016	AN	3	Ross Elementary	535 S. Walnut St.	Anaheim, CA	92802	CUR	1005	176		163	88	201	17.5%	5-12	83	47.2%	12	1008	58	28	3	3	1	5		2
9/28/2015	GG	3	Russell Elementary	600 S. Jackson	Santa Ana, CA	92704	NEW	719	291	291	260	91	336	40.5%	5-12	123	42.3%	24	704	94	62	7	29	9	27	19	4
4/19/2016	MA	2	Salk Elementary	1411 S. Gilbert St.	Anaheim, CA	92804	NEW	849	85	85	80	31	116	10.0%	5-12	43	50.6%	5	865	28	19	2	9	2			
9/29/2015	CE	3	San Marino Elementary	6215 San Rolando Way	Buena Park, CA	90620	CUR	583	121		114	41	139	20.8%	5-12	48	39.7%	8	635	48	25	3	18	2	10	8	1
3/8/2016	MA	2	Schweitzer Elementary	229 S. Dale Ave.	Anaheim, CA	92804	NEW	635	64	64	60	21	48	10.1%	5-12	38	59.4%	9	677	21	22	6	5	1	1		2
10/8/2015	SA	3	Sepulveda Elementary	1801 S. Poplar St.	Santa Ana, CA	92704	NEW	482	120	120	97	40	105	24.9%	5-12	86	71.7%	27	487	34	45	7	20	3	18	16	1
5/2/2016	NM	4	Sonora Elementary	966 Sonora Rd.	Costa Mesa, CA	92626	NEW	527	164	164	142	59	185	31.1%	5-12	79	48.2%	9	527	48	3	2	1				
9/1 & 9/8/15	AN	5	Sunkist Elementary	500 N. Sunkist St.	Anaheim, CA	92806	CUR	875	288		277	123	380	32.9%	5-12	138	47.9%	15	945	97	69	9	32	8	28	13	
5/12/2016	GG	4	Sunnyside Elementary	9972 East Russell Ave.	Garden Grove, CA	92844	NEW	698	266	266	204	85	257	38.1%	5-12	152	57.1%	26	699	130	1				1		
9/21/2015	CE	2	Temple Elementary	7800 Holder St.	Buena Park, CA	90620	CUR	504	113		106	32	107	22.4%	5-12	39	34.5%	4	532	42	13	6	13		4	2	
1/28/2016	TU	1	Thorman Elementary	1402 Sycamore Ave	Tustin, CA	92780	TAR	572	162	162	145	72	189	28.3%	5-12	89	54.9%	23	591	41	56	6	18	8	23	8	2
2/16/2016	TU	2	Tustin Ranch Elementary	12950 Robinson Dr.	Tustin, CA	92782	NEW	655	83	83	68	30	111	12.7%	5-12	33	39.8%	2	668	34	17	1	9	2	9	4	1
& 12/9/15	TU	1	Veeh Elementary	300 South C St.	Tustin, CA	92780	TAR	429	134	134	115	48	166	31.2%	5-12	65	48.5%	12	403	37	32	9	19	5	12	5	3
11/9/2015	CY	2	Vessels Elementary	5900 Cathy Ave.	Cypress, CA	90630	TAR	685	43	43	37	0	0	6.3%	5-12	18	41.9%	0	708	22	7	2		2	1	3	
5/9/2016	NM	2	Victoria Elementary	1025 Victoria St.	Costa Mesa, CA	92627	NEW	363	82	82	73	25	97	22.6%	5-12	47	57.3%	6	388	30	3						
3/31/2016	GG	3	Violette Elementary	12091 Lampson Ave.	Garden Grove, CA	92840	CUR	562	274		254	111	308	48.8%	5-12	91	33.2%	25	542	101	76	10	35	6	5		2
1/14/2016	GG	2	Wakeham Elementary	7772 Chapman Ave	Garden Grove, CA	92840	CUR	354	87		81	39	102	24.6%	5-12	45	51.7%	8	368	33	24	6	6	4	9	1	
4/18/2016	MA	2	Walter Elementary	10802 Rustic Ln.	Anaheim, CA	92804	NEW	607	172	172	138	54	202	28.3%	5-12	64	37.2%	14	669	52	35	9	13	3			
5/5/2016	GG	4	Warren Elementary	12871 Estock Dr.	Garden Grove, CA	92840	NEW	469	246	246	232	112	366	52.5%	5-12	140	56.9%	17	531	95	5						
1/7/2016	WE	2	Webber Elementary	14142 Hoover St	Westminister, CA	92683	CUR	362	114		105	53	142	31.5%	5-12	62	54.4%	17	371	45	25	3	14	5	11	4	1
2/4/2016	OV	3	Westmont/Lake View Elementa	8251 Heil Ave.	Westminister, CA	92801	CUR	912	149		131	59	148	16.3%	5-12	76	51.0%	14	628	59	39	1	19	5	14	11	1
& 4/11/16	NM	5	Whittier Elementary	1800 Whittier Ave.	Costa Mesa, CA	92627	NEW	715	345	345	280	127	371	48.3%	5-12	177	51.3%	27	744	88	99	9	44	7	7		4
5/31/2016	NM	3	Wilson Elementary	801 W. Wilson St.	Costa Mesa, CA	92627	NEW	477	89	89	80	67	176	18.7%	5-12	52	58.4%	7	486	24							
3/21/2016	GG	2	Woodbury Elementary	11362 Woodbury Rd.	Garden Grove, CA	92843	NEW	427	162	162	144	63	215	37.9%	5-12	81	50.0%	18	477	50	35	4	27				
10/31/2016	GG	2	Anthony Elementary	15320 Pickford St.	Westminster, CA	92683	CUR	418	98		82	22	71	22.4%	5-12	48	49.0%	14	440	68	23	2	19	1	6		3
12/2/2016	GG	3	Anthony Elementary	15320 Pickford St.	Westminster, CA	92683	CUR	475	77		67	38	94	49.4%	5-12	45	58.4%	5									
& 11/1/2016	MA	4	Baden Powell Elementary	2911 W. Stonnybrook Dr.	Anaheim, CA	92804	CUR	661	207		186	66	209	31.9%	5-12	125	60.4%	31	721	84	46	8	25	2	4	2	5
10/27/2016	TU	2	Benson Elementary	12712 Elizabeth Way	Tustin, CA	92780	CUR	380	126		85	37	105	29.4%	5-12	70	55.6%	17	393	58	42	11	3	5		4	
10/6/16 & 10/10/16	TU	5	Beswick Elementary	1362 Mitchell Ave.	Tustin, CA	92780	CUR	600	303		262	118	352	38.9%	5-12	183	60.4%	39	612	102	78	13	53	6	8	1	7
5/8,9 & 11/2017	AN	3	Betsy Ross Elementary	535 S. Walnut St.	Anaheim, CA	92802	CUR	928	179		166	60	159	33.5%	5-12	100	55.9%	12	1103	58	29	10	24	4	6		3
1/9/2017	GG	2	Brookhurst Elementary	9821 Catherine Ave.	Garden Grove, CA	92841	CUR	532	156		149	33	96	21.2%	5-12	100	64.1%	21	500	48	23	6	23	3	7	1	2
4/17&18 & 5/2,30/2017	GG	4	Bryant Elementary	8371 Orangewood	Garden Grove, CA	92841	CUR	700	323		299	103	283	31.9%	5-12	207	64.1%	23	733	126	72	7	42	11	22		2
5/16 & 5/22/2017	CE	2	Buena Terra Elementary	8299 Holder St.	Buena Park, CA	90620	CUR	530	137		120	18	70	13.1%	5-12	62	45.3%	7	544	4	2	1		1			
3/7,9,10, & 13/2017	GG	4	Clinton Elementary	13641 Clinton St.	Garden Grove, CA	92843	CUR	651	215		185	50	149	23.3%	5-12	115	53.5%	16	684	77	50	1	35	6	12		2
6/2/2016	NM	2	College Park Elementary	2380 Notre Dame Rd.	Costa Mesa, CA	92626	NEW	575	87	87	78	34	79	39.1%	5-12	52	59.8%	8	546	29	25	2	10	4	3	1	1
9/29/2016	GG	3	Cook Elementary	9802 Woodbury Ave.	Garden Grove, CA	92844	CUR	353	178		167	82	221	46.1%	5-12	98	55.1%	16	367	101	30	2	13	1	5		
4/10,11,14/2017	SA	3	Davis Elementary	1405 French St.	Santa Ana, CA	92701	CUR	639	203		182	66	170	32.5%	5-12	159	78.3%	28	557	110	1	1	41	6	18		

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2/6/17 & 2/7/17	SA	3	Diamond Elementary	1450 S. Center St.	Santa Ana, CA	92704	CUR	542	238		218	45	153	18.9%	5-12	166	69.7%	31	547	35	45	5	19	9	20		
12/12/16 & 2/3/17	MA	4	Disney Elementary	2323 W. Orange Ave.	Anaheim, CA	92804	CUR	659	138		224	75	246	54.3%	5-12	138	100.0%	21	666	128	15	4	18	2	5	1	1
5/15/2017	CE	1	Dysinger Elementary	7770 Camellia Dr.	Buena Park, CA	90620	CUR	480	181		173	14	47	7.7%	5-12	105	58.0%	11	491	44	27	7	2	1	9		4
8/23/2016	AN	2	Edison Elementary - Tracks A&B	1526 E. Romneya	Anaheim, CA	92805	CUR	494	117		111	38	83	32.5%	5-12	74	63.2%	17	250								
9/20/2016	AN	2	Edison Elementary (Tracks C&D)	1526 E. Romneya	Anaheim, CA	92805	CUR	414	101		94	25	83	24.8%	5-12	71	70.3%	11	265	62	91	8	20	4	10	8	3
11/3/16 & 11/4/16	TU	4	Estock Elementary	14741 North B Street	Tustin, CA	92780	CUR	640	289		259	76	192	26.3%	5-12	179	61.9%	27	673	119	81	8	28	4	13	1	4
12/15/2016	TU	1	Estock Elementary (Add'l Sealant Day)	14741 North B St.	Tustin, CA	92780	CUR					44	94	#DIV/0!	5-12		#DIV/0!										
1/10/2017	GG	3	Faylane Elementary	11731 Morrie Lane	Garden Grove, CA	92840	CUR	610	172		157	55	186	32.0%	5-12	104	60.5%	18	550	64	11	6	18	2	1		2
11/17/2016	TU	2	Foss Elementary	18492 Vanderlip Ave.	Santa Ana, CA	92705	CUR	460	131		120	43	121	32.8%	5-12	78	59.5%	11	476	65	31	2	10		2	2	1
9/15/16 & 9/20/16	AN	4	Franklin Elementary (Anaheim)	521 W. Water St.	Anaheim, CA	92805	CUR	855	316		291	121	325	38.3%	5-12	186	58.9%	38	862	121	89	13	33	2	5	3	8
10/20/15 & 10/25/16	SA	5	Franklin Elementary (Santa Ana)	210 W. Cubbon St.	Santa Ana, CA	92701	CUR	450	205		186	92	244	44.9%	5-12	131	63.9%	27		61	70	9	19	1	3	2	1
1/23 & 26/2017	GG	2	Gilbert Elementary	9551 Orangewood Ave.	Garden Grove, CA	92841	CUR	543	146		138	30	91	20.5%	5-12	99	67.8%	18	580	73	11	2	13	1	3		1
3/13,14,16 & 4/11/2017	SA	4	Glenn Martin Elementary	939 W. Wilshire Ave.	Santa Ana, CA	92707	CUR	698	311		297	142	311	45.7%	5-12	191	61.4%	34	673	125	69	4	31	3	16		3
3/27,28,31/ 2017	SA	3	Harvey Elementary	1635 S. Center St.	Santa Ana, CA	92704	CUR	455	158		146	35	104	22.2%	5-12	121	76.6%	19	469	75	54	6	31	2	14		1
10/24/16 & 10/27/16	GG	4	Hazard Elementary	4218 W. Hazard Ave.	Santa Ana, CA	92703	CUR	545	238		217	71	227	29.8%	5-12	140	58.8%	32	567	142	63	10	21	2	4	2	1
11/8/16, 11/14/16 & 11/15/16	TU	5	Heideman Elementary	15571 Williams St.	Tustin, CA	92780	CUR	650	326		292	56	172	17.2%	5-12	177	54.3%	32	620	105	85	7	22	2	11	1	6
1/6/2017	TU	1	Heideman Elementary (Add'l Sealant Day)	15571 Williams St.	Tustin, CA	92780	CUR					45	132	#DIV/0!	5-12		#DIV/0!										
2/9/2017	GG	3	Heritage Elementary	426 S. Andres Place	Santa Ana, CA	92704	CUR	541	134		124	79	189	59.0%	5-12	81	60.4%	7	585	98	32		24	3	16		2
4/20 & 24/2017	GG	3	Heritage Elementary	426 S. Andres Place	Santa Ana, CA	92704	CUR	541	130		118	63	160	48.5%	5-12	50	38.5%	10									
11/15/16 & 11/18/16	GG	2	Hill Elementary	9681 11th St.	Garden Grove, CA	92844	CUR	370	137		116	34	83	60.6%	5-12	80	58.4%	16	375	18	25	2	22		6	3	
6/7/2016	SA	3	Jackson Elementary	1143 S. Nakoma Dr.	Santa Ana, CA	92704	CUR	990	269		258	93	296	34.6%	5-12	187	69.5%	23	851	79	170	28	70	20	37	13	6
4/24,25,27/ 2017	SA	3	Jackson Elementary	1143 S. Nakoma Dr.	Santa Ana, CA	92704	CUR	925	243		218	88	235	36.2%	5-12	152	62.6%	25	933								
10/18/16 & 10/20/16	GG	3	Lawrence Elementary	12521 Monroe	Garden Grove, CA	92841	NEW	600	188	188	162	52	180	27.7%	5-12	137	72.9%	29	599	80	62	5	17		7		2
4/6/2017	CE	2	Los Coyotes Elementary	8122 Moody St.	La Palma, CA	90623	CUR	535	262		236	47	157	17.9%	5-12	43	16.4%	4	540	49	21		33	1	8		2
1/12/17 & 1/17/17	MA	4	Low Elementary	215 N. Ventura St.	Anaheim, CA	92801	CUR	635	188		178	85	231	45.2%	5-12	96	51.1%	26	634	61	29	10	16	5	9	3	3
4/13,14,18, 21 & 9/8/16	SA	5	Lowell Elementary	700 S. Flower St.	Santa Ana, CA	92703	CUR	844	319		286	145	431	45.5%	5-12	165	51.7%	46	861	126	70	8	36	2	16		4
9/22/16	AN	4	Mann Elementary	600 W. La Palma Ave.	Anaheim, CA	92801	CUR	876	133		124	53	142	39.8%	5-12	90	67.7%	18		83	72	6	27	3	5	6	3
8/25/2016	AN	2	Mann Elementary - Tracks A&B	600 W. La Palma Ave.	Anaheim, CA	92801	CUR	438	100		83	19	43	19.0%	5-12	68	68.0%	14	727								
10/17/2016 & 11/8/16	MA	4	Marshall Elementary	2627 Crescent Ave.	Anaheim, CA	92801	CUR	700	251		226	77	218	30.7%	5-12	139	55.4%	23	736	130	61	5	13	4	11	2	2
1/17/2017	GG	2	Marshall Elementary	15791 Bushard Ave.	Westminster, CA	92683	CUR	414	169		158	31	109	18.3%	5-12	117	69.2%	23	423	61	23	4	11	2	4	2	1
12/1/16 & 12/9/16	MA	5	Maxwell Elementary	2613 W. Orange Ave.	Anaheim, CA	92804	CUR	822	228		213	66	183	28.9%	5-12	142	62.3%	29	857	70	28	4	32	2	10	2	1
5/1,4, & 5/2017	CE	3	Miller Elementary	7751 Furman Rd.	La Palma, CA	90623	CUR	578	146		134	57	155	39.0%	5-12	51	34.9%	1	614	36	18	3	20		6		4
1/19/17 & 1/31/17	GG	4	Mitchell Elementary	13451 Taft Ave.	Garden Grove, CA	92843	CUR	453	181		170	30	71	16.6%	5-12	122	67.4%	23	471	87	14	6	18		3	2	
11/7/2016	TU	2	Nelson Elementary	14392 Browning Ave.	Tustin, CA	92780	CUR	545	155		137	35	112	22.6%	5-12	74	47.7%	14	562	53	29	3	19		4	1	3
1/27/2017	GG	3	Newhope Elementary	4419 West Regent Dr.	Santa Ana, CA	92704	CUR	411	123		113	51	168	41.5%	5-12	41	33.3%	6	420	33	4	3	6	1		1	1
10/25/2016	AN	2	Orange Grove Elementary	1000 S. Harbor Blvd.	Anaheim, CA	92805	NEW	690	120	120	108	23	65	19.2%	5-12	67	55.8%	18	681	33	38	8	15	1	3	3	3
2/14/2017	GG	2	Parkview Elementary	12272 Wilken Way	Garden Grove, CA	92840	CUR	520	119		115	15	60	12.6%	5-12	78	65.5%	7	549	11	47	3	27	4	25		1
3/24 & 29/2017	GG	2	Parkview Elementary	12272 Wilken Way	Garden Grove, CA	92840	CUR	500	106		93	38	98	35.8%	5-12	58	54.7%	6									

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3/20,21,23, 30,31/2017; 4/3,4,20/20 17	GG	8	Peters Elementary	13162 Newhope St.	Garden Grove, CA	92843	CUR	1290	559		509	164	464	29.3%	5-12	324	58.0%	40	1302	199	125	8	94	14	44		5
2/27/17 & 2/28/17	SA	3	Pio Pico Elementary	931 W. Highland St.	Santa Ana, CA	92703	CUR	600	237		226	50	163	21.1%	5-12	173	73.0%	29	618	8	74	4	36	4	32	2	2
3/2/2017	SA	1	Pio Pico Elementary	931 W. Highland St.	Santa Ana, CA	92703	CUR	600				50	167	21.1%	5-12		#DIV/0!										
6/13/2016	NM	3	Pomona Elementary	2051 Pomona Ave.	Costa Mesa, CA	92627	CUR	512	265		212	67	206	25.3%	5-12	139	52.5%	15	523	90	70	7	29	5	18	1	1
9/1/16 & 9/19/16	AN	5	Ponderosa (Tracks C&D)	2135 S. Mountain View Ave.	Anaheim, CA	92802	CUR	530	313		279	125	338	39.9%	5-12	203	64.9%	39	552	148	152	29	71	15	13	9	5
8/26/2016	AN	2	Ponderosa Elementary - A&B	2135 S. Mountain View Ave.	Anaheim, CA	92802	CUR	530	177		162	57	129	32.2%	5-12	116	65.5%	28	530								
6/6/2016	GG	4	Post Elementary	14641 Ward Street	Westminster, CA	92683	NEW	536	236	236	220	88	330	37.3%	5-12	127	53.8%	24	562	214	58	7	58	4	15		4
2/16/17 & 2/17/17	GG	4	Post Elementary	14641 Ward St.	Westminster, CA	92683	CUR	520	224		201	76	217	33.9%	5-12	130	58.0%	16	526								
11/14/16 & 11/18/16	MA	3	Pyles Elementary	10411 S. Dale St.	Stanton, CA	90680	CUR	742	229		197	32	97	14.0%	5-12	117	51.1%	31	785	85	53	11	19		8	3	4
1/25/2017	MA	1	Pyles Elementary (Add'l Sealant Day)	10411 S. Dale St.	Stanton, CA	90680	CUR					21	77	#DIV/0!	5-12		#DIV/0!										
5/11,12 & 16/2017	CE	3	Raymond Temple Elementary	7800 Holder St.	Buena Park, CA	90620	CUR	540	198		174	44	139	22.2%	5-12	89	44.9%	18	569	22	12	4	8	3	2		3
22 & 24/2017	AN	5	Revere Elementary	140 W. Guinida Lane	Anaheim, CA	92805	CUR	871	299		278	138	397	46.2%	5-12	140	46.8%	21	941	98	54	2	40	4	21		5
2/21/17 & 2/24/17	GG	4	Riverdale Elementary	13222 Lewis St.	Garden Grove, CA	92843	CUR	580	266		238	51	164	19.2%	5-12	174	65.4%	23	588	37	50	8	71	3	15		4
3/15/2017	GG	4	Riverdale Elementary	13222 Lewis St.	Garden Grove, CA	92843	CUR	550				30	90	11.3%	5-12		#DIV/0!										
2/23/17 & 2/24/17	GG	5	Rosita Elementary	4726 Hazard Ave.	Santa Ana, CA	92703	CUR	500	231		214	68	354	29.4%	5-12	142	61.5%	25	522	11	59	8	46	3	23	2	1
3/1/2017 & 3/21/17	GG	2	Rosita Elementary	4726 Hazard Ave.	Santa Ana, CA	92703	CUR	500				69	205	29.9%	5-12		#DIV/0!										
9/26/16 & 9/27/16	GG	5	Russell Elementary	600 S. Jackson St.	Santa Ana, CA	92704	CUR	690	301		281	102	329	33.9%	5-12	209	69.4%	51	628	112	114	7	22	6	9	11	3
11/29/16 & 12/1/16	MA	1	Salk Elementary	1411 S. Gilbert St.	Anaheim, CA	92804	CUR	800	119		109			0.0%	5-12	67	56.3%	16	838	78	41	4	19		8	1	3
12/1/2016	MA	2	Salk Elementary	1411 S. Gilbert St.	Anaheim, CA	92804	CUR	849	85		81	66	195	77.6%	5-12	33	38.8%	7									
5/22 & 23/2017	CE	2	San Marino Elementary	6215 San Rolando Way	Buena Park, CA	90620	CUR	580	218		198	31	109	14.2%	5-12	105	48.2%	11	586								
10/1/2016	MA	2	Schweitzer Elementary	229 S. Dale Ave.	Anaheim, CA	92804	CUR	635	159		147	42	121	26.4%	5-12	124	78.0%	20	665	73	49	4	14	2	3	7	3
2/2/17 & 2/7/17	SA	3	Sepulveda Elementary	1801 S. Poplar St.	Santa Ana, CA	92704	CUR	415	188		168	48	111	25.5%	5-12	109	58.0%	24	424	59	22	6	17	1	4		1
3/1 & 3/2/2017	SA	1	Sepulveda Elementary	1801 S. Poplar St.	Santa Ana, CA	92704	CUR	415				19	46	10.1%	5-12		#DIV/0!										
3/6, 3/9 & 3/10/17 & 4/7/17	GG	4	Simmons Elementary	11602 Steele Dr.	Garden Grove, CA	92841	NEW	453	222	222	206	57	182	25.7%	5-12	146	65.8%	25	445	103	59	2	38	4	25		
9/13/16, & 5/18,19,23 & 26/2017	AN	4	Sunkist Elementary	500 N. Sunkist St.	Anaheim, CA	92806	CUR	864	365		343	137	386	37.5%	5-12	230	63.0%	44	899	83	97	5	55	7	10	4	7
	GG	4	Sunnyside Elementary	9972 E. Russell Ave.	Garden Grove, CA	92844	CUR	665	227		199	74	219	32.6%	5-12	101	44.5%	21	683	8	5	2	2	1			
12/1/16 & 1/5/17	TU	6	Thorman Elementary	1402 Sycamore Ave.	Tustin, CA	92780	CUR	573	281		263	105	298	37.4%	5-12	179	63.7%	39	601	71	44	15	28	7	13	3	5
12/13/2016	TU	2	Tustin Ranch Elementary	12950 Robinson Dr.	Tustin, CA	92782	CUR	646	150		132	19	71	12.7%	5-12	63	42.0%	11	638	88	10	4	14		3		
12/8/16 & 1/30/17	TU	4	Veeh Elementary	300 South C St.	Tustin, CA	92780	CUR	432	170		164	63	181	37.1%	5-12	103	60.6%	17	451	58	21	9	24	2	3	2	2
4/3,4,25, & 27/2017	GG	4	Violette Elementary	12091 Lampson Ave.	Garden Grove, CA	92840	CUR	500	224		209	102	262	45.5%	5-12	125	55.8%	15	504	93	49	3	31	5	18		2
10/4/2016	GG	2	Wakeham Elementary	7772 Chapman Ave.	Garden Grove, CA	92840	CUR	344	100		79	33	110	33.0%	5-12	85	85.0%	22	343	43	38	6	9	2	3	2	1
12/6/16 & 1/10/17	MA	4	Walter Elementary	10802 Rustic Lane	Anaheim, CA	92804	CUR	624	161		144	47	125	29.2%	5-12	105	65.2%	15	658	70	24	2	11	5	7	1	
3/2,6,7 & 4/3/17	GG	5	Warren Elementary	12871 Estock Dr.	Garden Grove, CA	92840	CUR	488	212		203	99	270	46.7%	5-12	111	52.4%	18	530	72	154	3	36	2	27		
5/25,26 & 30/2017	SA	3	Washington Elementary	910 W. Anahurst Pl.	Santa Ana, CA	92704	NEW	823	153	153	128	58	174	37.9%	5-12	84	54.9%	12	825								
6/3/2016	NM	3	Wilson Elementary	801 W. Wilson St.	Costa Mesa, CA	92627	NEW	477	111	111	100	67	176	60.4%	5-12	12	10.8%	10	486	32	36	4	18	3	16	4	1
6/9/2016	SA	4	Wilson Elementary	1317 N. Baker St.	Santa Ana, CA	92706	CUR	720	294		266	133	266	45.2%	5-12	150	51.0%	33	749	88	73	8	39	4	16	14	1
1/26/2017	GG	2	Woodbury Elementary	11362 Woodbury Rd.	Garden Grove, CA	92843	CUR	410	92		84	26	68	28.3%	5-12	41	44.6%	5	440	64	17	2	23	3	5		

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CC	225	34	
DI	569	29	
MA	448	24	
BE	349	20	
ES	361	28	
WE	358	13	
DA	642	38	
PA	538	36	
WA	347	21	
HE	632	23	
LO	911	36	
AN	466	24	
TH	570	21	
HA	679	40	
RE	678	28	
WES	594	34	
PE	1238	24	
HO	533	24	
TR	643	25	
CE	522	28	
LO	703	26	
RO	510	25	
BP	676	32	
BR	744	26	
	13936	659	14595

	Target	New	Screenings
1st	2	0	1492
2nd	10	4	4023
3rd	5	8	3091
4th			
	17	12	8606

IGT 5 Requests for Proposal
1. Access to Children's Dental Services

Appl. ID #	Organization Name	Request ($)	Project Title	Proposed Partners	Project Description	Additional CalOptima Members Served	Initial Assessment	Site Visit	Financial Assessment	Comments
198	Coalition of Orange County Community Health Centers	$ 1,000,000	Mouths Matter: Establishing a Dental Home for All Children	• Families Together of Orange County (FQHC Look-Alike in Tustin and expanding to Anaheim) • Korean Community Services (FQHC Look-Alike in Buena Park) • North Orange County Regional Health Foundation (FQHC Look-Alike in Fullerton) • Serve the People (FQHC in Santa Ana) • Southland Integrated Services (FQHC in Garden Grove) • Anaheim Union High School District • Boys and Girls Clubs • Buena Park School District • Centralia School District • Fullerton School District • Hands Together • KidWorks • Lighthouse Community Centers • Project Access • Rancho Santiago Community College District • Santa Ana Unified School District • The Cambodian Family • Tustin Unified School District	Provide a dental home with a mobile dental unit equipped to provide pediatric preventive and restorative treatment, thereby completing the circle of dental care. This project will enable five federally qualified health centers (FQHC) and FQHC Look-Alikes to establish a dental home with regular and emergency care for children and families	9,000	4.87	Yes	Yes	• The project will expand pediatric dental services with preventative and restorative dental care • There is no mention of the Dental Transformation Initiative (DTI) in the proposal and whether the propose project will be different from DTI or a continuation of DTI • Unsure of how safety net clinic/co-lead would maintain staffing <u>Site Visit:</u> • The collaborative clinics are very passionate of the work • One of the five clinics currently does no have a fixed site dental program, they will need to build out a program • For all sites a mobile unit will need to be built out to implemented the mobile dental program • Not entirely clear on the implementation of the program
191	Healthy Smiles for Kids of Orange County	$ 1,000,000	Full Cycle Dentistry	• Smile Center in Garden Grove • Smile Clinic at CHOC Children's • Garden Grove Unified School District • Santa Ana Unified School District • Westminster Unified School District • Anaheim Unified School District • Buena Park Unified School District • La Palma Unified School District • Tustin Unified School District • Fountain Valley Unified School District • Stanton Unified School District • Placentia Unified School District • Fullerton Unified School District • USC's Herman Ostrow School of Dentistry	Provide preventive (screenings, dental cleanings, fluoride, sealants) and restorative treatment (fillings and cavity treatment) to CalOptima children at schools, primary care clinics, and community sites. Children who require advanced restorative treatment (such as treatment under general anesthesia) will be referred to traditional clinics in Garden Grove and CHOC Children's Hospital.	13,564	4.65	Yes	Yes	• Project will expand services and ramp-up of mobile restorative program for all four mobile and a new mini clinic • Organization has deep knowledge and experience providing comprehensive dental services and link member back to a dental home • Mobile unit can be up and running in three months for immediate impact <u>Site Visit:</u> • Well established organization and supportive leadership • Presentation was well organized • Goals and objective are well understood

Summary: Provided to IGT 5 Board Ad Hoc Committee

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
12. Consider Adopting Resolution Authorizing and Directing Execution of Contract with the California Department of Aging for the Multipurpose Senior Services Program

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

Recommended Action
Adopt Board Resolution No. 20-0604-01, authorizing and directing the Chairman of the Board to execute Contract MS-20-21-41 with the California Department of Aging for the Multipurpose Senior Services Program for Fiscal Year 2020-21.

Background
The Multipurpose Senior Services Program (MSSP) is a home and community-based services program, operated pursuant to a waiver in the State's Medi-Cal program. MSSP provides case management of social and health care services as a cost-effective alternative to institutionalization of the frail elderly.

The California Department of Health Care Services (DHCS), through an Interagency Agreement, delegates the administration of the MSSP to the California Department of Aging (CDA). The CDA contracts with local government entities and private non-profit organizations for local administration of MSSP in various areas of the State.

As the operator of the MSSP site for Orange County, CalOptima improves the quality of care for our aging population by linking frail, elderly members to home and community-based services as an alternative to institutionalization and helps to contain long-term care costs by reducing unnecessary or inappropriate nursing facility placements. CalOptima has successfully implemented the MSSP program over the past 19 years for up to a maximum of 568 members at any given point in time. Currently, CalOptima serves approximately 446-460 members.

Discussion
Prior to the May 14, 2020 release of the Governor's "May Revision" to the proposed FY2020-21 budget for the State of California, CalOptima received CDA Contract MS-20-21-41 (CDA Contract) for execution by the Chairman of the CalOptima Board, which, upon the adoption of a Board resolution and execution of the contract would extend the MSSP through June 30, 2021, with the maximum amount of the contract set at $2,437,071. However, as work continues in addressing the very significant financial challenges the State is facing as a result of the COVID-19 pandemic, the May Revision assumes the elimination of a number of programs, including MSSP, no sooner than July 1, 2020. Because the State's budget and the timing of any program modifications and/or eliminations have not yet been finalized, Staff recommends that the Board authorize execution of the CDA Contract so that CalOptima remains fully prepared to continue to operate the MSSP program, but with the understanding that the CDA may

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not ultimately be in a position to countersign the agreement if, as reflected in the May Revision, the MSSP program is eliminated.

The scope of work and other obligations included in CDA Contract are consistent with existing contract obligations. In addition to primarily wording and technical revisions, there are some proposed clarifications regarding the content of future audits and the responsibility of CalOptima MSSP in these audits. These responsibilities include cooperating with authorized representatives of federal or State government and inserting contract language with independent audit firms to ensure audit documents are made available if requested. There is also a proposed language revision to indicate expenditures should be reconciled to the total budget allocation.

In the event that MSSP is not eliminated and the CDA Contract is fully executed as is, staff does not anticipate that any of the changes from the current agreement would have a significant operational or financial impact as they are largely already in operation.

Effective July 1, 2015, with the implementation of the Coordinated Care Initiative (CCI) in Orange County, DHCS included MSSP enrollment in the established Medi-Cal capitation rate development methodology. Under the CCI program, MSSP was scheduled to transition to a managed care benefit on January 1, 2023. However, DHCS discontinued the CCI program effective January 1, 2018, and subsequently cancelled the MSSP scheduled transition.

Prior to the May Revision and the proposed elimination of MSSP, the plan was that, effective January 1, 2021, MSSP would operate as a benefit under the 1915(c) Medicaid waiver. At that time, MSSP, which currently operates within CalOptima's Long Term Services and Supports (LTSS) Department was expected to transition back to a waiver benefit as it did prior to implementation of CCI in 2015. Under that scenario, Staff anticipated that some of the attached contract language referring to non-CCI models would not apply through December 31, 2020.

Fiscal Impact

Subject to the State funding the program and not eliminating the MSSP program, associated revenues and expenses are budgeted items and are included in the proposed CalOptima Fiscal Year (FY) 2020-21 Operating Budget pending Board approval.

Rationale for Recommendation

Adoption of Board Resolution No. 20-0604-01, authorizing and directing the Chairman of the Board of Directors to execute the FY 2020-21 contract with the CDA for the MSSP program will allow CalOptima to continue to address the long-term community care needs of some of the frailest older adult CalOptima members by helping them to remain in their homes, assuming the MSSP program is not eliminated, as reflected in the Governor's May Revision to the proposed FY2020-21 state budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Board Resolution No. 20-0604-01, Execute Contract No. MS-20-21-41 with the State of California Department of Aging for the Multipurpose Senior Services Program

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

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RESOLUTION NO. 20-0604-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima

EXECUTE CONTRACT NO. MS-20-21-41
WITH THE STATE OF CALIFORNIA
DEPARTMENT OF AGING FOR THE
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

WHEREAS, The Orange County Health Authority, d.b.a. CalOptima ("CalOptima") continues to provide services as a Multipurpose Senior Service Program Site under contract with the California Department of Aging; and,

WHEREAS, the California Department of Aging notified CalOptima of its intent to contract for the assignment of up to 460 MSSP participant slots to CalOptima; and,

WHEREAS, the California Department of Aging has requested the execution of Contract MS-20-21-41; and,

WHEREAS, the Board of Directors has determined that it is in the best interest of the ongoing development of CalOptima home and community-based services to the Medi-Cal beneficiaries residing in Orange County to approve CalOptima executing the Contract.

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima is hereby authorized to enter into contract MS-20-21-41 with the State of California Department of Aging on the terms and conditions set forth in the form provided to this Board of Directors; and,

II. That the Chair of this Board of Directors is hereby authorized and directed to execute and deliver the Contract by and on behalf of CalOptima on the terms and conditions set forth in the form provided to this Board of Directors.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 4th day of June 2020.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost, M.D., Chair, Board of Directors

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

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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

13. Consider Authorizing and Directing Execution of Amendment to the Agreement with the California Department of Health Care Services for the CalOptima Program of All-Inclusive Care for the Elderly

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute Amendment A10 to the Program of All-Inclusive Care for the Elderly (PACE) Agreement between the California Department of Health Care Services (DHCS) and CalOptima regarding extension of the contract termination date to December 31, 2020 and adding the Calendar Year (CY) 2020 capitation rates.

Background

Since October 2009, the CalOptima Board has taken numerous actions related to the CalOptima PACE program. On June 6, 2013, the Board authorized the execution of the PACE Agreement between DHCS and CalOptima (DHCS PACE Agreement) as well as the agreement with the Centers for Medicare & Medicaid Services (CMS) for the operation of the CalOptima PACE site. Beginning in September 2015 and thereafter, the Board has authorized execution of various amendments to the DHCS PACE Agreement for CY payment rates and other provisions, as summarized in the Appendix to this agenda item.

The CalOptima DHCS PACE Agreement specifies, among other terms and conditions, the capitation payment rates CalOptima receives from DHCS to provide PACE participants with health care services. The current DHCS PACE Agreement expires on June 30, 2020, with the capitation rates renewed on a calendar year basis.

Discussion

On May 4, 2020, DHCS provided CalOptima with Amendment A10 for the DHCS PACE Agreement to include updates for:

- Extending the contract termination date through December 31, 2020;
- Increasing the maximum amount payable to accommodate the additional 6-months of the contract;
- A new marketing provision that specifies a PACE organization's responsibility for the activities of contracted individuals or entities who market on their behalf; and
- Implementing the CY 2020 capitation rates retroactive to January 1, 2020.

The DHCS PACE Agreement is being extended for another 6-month period, to provide DHCS with additional time to finalize proposed updates to the DHCS PACE Agreement template and vet proposed changes with stakeholders. With the proposed amendment, all other terms and conditions in the CalOptima DHCS PACE Agreement remain the same. On June 21, 2019, DHCS released the initial draft version of the

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new DHCS PACE Agreement template for an opportunity to comment on the proposed changes. CalOptima staff submitted feedback, as did the CalPACE Association and other PACE organizations operating in other parts of the State. DHCS is currently in the process of reviewing all the feedback it received and will be hosting a call with all PACE Organizations at a future date to be determined, after its review has been completed to discuss the updates that will be finalized. CalOptima is pending receipt of the new/updated draft with the feedback incorporated from the initial comment period. CalOptima staff will return to the Board once the new/updated contract version is issued, as the new DHCS PACE Agreement template is expected to replace the existing DHCS PACE Agreement (DHCS is referring to this process as the "Contract Overhaul"), instead of adding on subsequent Amendments.

Language Updates (Exhibit A)

This amendment incorporates additional language updates for the following provision:

1. Exhibit A, Attachment 15 - Marketing, Provision 1. *Training and Approval of Marketing Representatives*
   - Amended to add a new provision (D) providing that PACE organizations are responsible for the activities of contracted individuals or entities who market on their behalf, and requiring the development of a method to document that training has been provided on PACE program requirements to such contracted individuals and entities.

2. All other terms and conditions in the CalOptima DHCS PACE Agreement remain unchanged.

Rate Revisions – CY 2020 Rate Amendment (Exhibit B)

On November 27, 2019, DHCS provided CalOptima with the ***draft*** proposed rates for CY 2020, for the period of January 1, 2020 through December 31, 2020. The methodology used to develop the rates was based on the experience-based rates methodology that is informed by the Rate Development Template (RDT) process, which is consistent with the way DHCS develops rates for Managed Care Plans for the Medi-Cal program. DHCS is in the process of finalizing the CY 2020 rates and has been working with CMS since December 2019 for review and approval. Upon CMS approval, DHCS will provide PACE plans with a rate amendment to incorporate all program changes retroactive to the beginning of January 2020. CalOptima staff anticipates that the CY 2020 amendment will be consistent with the draft materials provided to date. In the event the proposed changes are materially different than anticipated, CalOptima staff will return to the Board with further recommendations.

Rate changes for the period January 1, 2020 through December 31, 2020 reflect the following:

- Revised capitation rates, retroactive to January 1, 2020;
- The revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population have built-in adjustments for Medi-Cal program changes; and
- All other terms and conditions in the CalOptima DHCS PACE Agreement remain unchanged.

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Fiscal Impact

The recommended action to execute Amendment A10 to the DHCS PACE Agreement increases the maximum allowed funding by $18.3 million to extend the contract termination date to December 30, 2020, under the same terms and conditions of the current agreement, except as described above. The funding amount is a budgeted item, with no additional fiscal impact. Management has incorporated draft Calendar Year (CY) 2020 and forecasted CY 2021 PACE capitation rates into the CalOptima Fiscal Year (FY) 2020-21 Operating Budget pending approval by the Board.

Rationale for Recommendation

CalOptima's execution of Amendment A10 to the DHCS PACE Agreement is necessary for the continued operation of CalOptima PACE after June 30, 2020.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to PACE Primary Agreements

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 13

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

Amendments to Primary Agreement with DHCS	Board Approval
A01 provided revised Upper Payment Limit (UPL) and capitation rates for Calendar Year (CY) 2013 for the period of October 1, 2013 through December 31, 2013; and UPL methodology and CY 2014 rates for the period of January 1, 2014 through December 31, 2014. Revised capitation rates for the Medi-Cal *Dual* population and *Medi-Cal only* population to have built-in adjustments for Medi-Cal program changes. Also incorporated adult expansion group into aid code table: a. Added adult expansion aid codes M1, L1, 7U under adult expansion group. b. Added aid codes 3D and M3 under Family group.	September 3, 2015
A02 provided revised UPL and capitation rates for CY 2015 for the period of January 1, 2015 through December 31, 2015. Revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population to have built-in adjustments for Medi-Cal program changes.	September 3, 2015
A03 provided revised UPL and capitation rates for CY 2016 for the period of January 1, 2016 through December 31, 2016, and applied the Managed Care Organization (MCO) Tax for the period July 1, 2016 through December 31, 2016. Beginning on January 1, 2017 and onward, the rates revert back to the non-MCO tax period rates in effect from January 1, 2016 through June 30, 2016, until the 2017 rates are developed and implemented with a future amendment to the CalOptima DHCS PACE Agreement. Incorporates a revised HIPAA Business Associate Addendum, Exhibit H, to replace the former Exhibit G, as of the Amendment effective date, which will require compliance with DHCS' revised data security standards.	May 4, 2017
Amend* contract to include revised language reflecting the Americans with Disabilities Act (ADA) for 508 compliance. *On 9/20/17, DHCS informed CalOptima this would be moved to be captured in A04.	August 3, 2017
A04 provided an extension of the contract termination date to December 31, 2018 and incorporated ADA compliance language.	December 7, 2017
Future Amendment (A05) provided draft capitation rates for CY 2017 for the period of January 1, 2017 through December 31, 2017, developed by the "Amount That Would Have Otherwise Been Paid (AWOP)", and apply the Managed Care Organization (MCO) Tax for the period January 1, 2017 through June 30, 2017.	December 7, 2017
A06 provided an extension of the contract termination date to December 31, 2019.	November 1, 2018

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Amendments to Primary Agreement with DHCS	Board Approval
A07 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2018 for the period of January 1, 2018 through December 31, 2018 and applies the Managed Care Organization (MCO) Tax for this period. First time rates for PACE developed using the Rate Development Template (RDT)/experience-based rate methodology. Incorporates additional language updates for various contract provisions, including restrictions on delegation as well as emergency preparedness.	April 4, 2019
A08 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2019 for the period of January 1, 2019 through December 31, 2019 and applies the Managed Care Organization (MCO) Tax for this period. Incorporates additional language updates for other contract provisions, including Nursing Facility Services payment rates.	September 5, 2019
A09 provided an extension of the contract termination date to June 30, 2020.	December 5, 2019
A10 provided an extension of the contract termination date to December 31, 2020 and also provides revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2020 for the period of January 1, 2020 through December 31, 2020.	**Pending**
Amendments to Primary Agreement with CMS	**Board Approval**
A01 CalOptima PACE initiated a waiver to allow Nurse Practitioners to provide primary care at PACE, which was approved by CMS on March 30, 2017 and added *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	December 1, 2016
A02 CalOptima PACE initiated a waiver to allow Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in CalOptima PACE, which was approved by CMS on March 12, 2018 and amended *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	September 7, 2017

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing Execution of Amendment to Agreement with the California Department of Health Care Services in Order to Continue Operation of the OneCare and OneCare Connect Programs

Contact

Silver Ho, Executive Director of Compliance, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment to Agreement 16-93274 between CalOptima and the California Department of Health Care Services (DHCS) in order to continue operation of the OneCare and OneCare Connect programs.

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 new five-year Primary and Secondary Agreements with DHCS that have been subsequently extended and amended. Amendments to these agreements are summarized in the attached appendix. Until 2016, the Primary Agreement included language that incorporated provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs).

In 2016, DHCS extracted the MIPPA-compliant language from the Primary agreement and placed it in a standalone agreement, Agreement 16-93274. The Chairman of CalOptima's Board of Directors executed that agreement, an action that was ratified during the August 2016 meeting of the Board.

Subsequently, the Chairman has executed three amendments to extend the contract termination date, pursuant to Board authority. Agreement 16-93274 is set to terminate on December 31, 2020. The agreement contains no rates of payment.

Discussion

Amendment to Agreement 16-93274

DHCS has notified CalOptima of its intention to provide CalOptima with a forthcoming amendment to extend Agreement 16-93274 for an additional year, through December 31, 2021. CalOptima has requested that DHCS send the amendment to CalOptima as soon as possible, in order to allow for immediate signature by CalOptima and prompt return to DHCS for countersignature.

The Centers for Medicare & Medicaid Services (CMS) requires that plans renewing their D-SNP programs must submit evidence of a MIPPA-compliant Medicaid contract for the 2021 contract year no later than July 6, 2020. Executing Amendment 04 (A-04) to Agreement 16-93274 is required in order

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for CalOptima to meet CMS's filing requirements, and to continue to operate CalOptima's D-SNP "OneCare" and its Cal MediConnect program "OneCare Connect" in contract year 2021.

The amendment is expected to contain language changes in addition to the extension of the expiration date. The language changes were not available as of the date that materials were due for the June 2020 meeting of the CalOptima Board of Directors but are expected within the next several weeks, if not sooner. Staff expects DHCS to propose language changes to the contract to meet the requirements contained in the October 7, 2019 CMS memorandum entitled "CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs)." After DHCS's proposed language changes have been received, staff will return to the Board to request a revised and updated authority as a matter of ratification.

Fiscal Impact
The recommended action to execute an Amendment to Agreement 16-93274 between CalOptima and DHCS is projected to be budget neutral.

Rationale for Recommendation
CalOptima's execution of Amendment 04 (A-04) to the Agreement 16-93274 with the DHCS is necessary to ensure that CalOptima meets CMS requirements in order for CalOptima to operate the OneCare and OneCare Connect programs during 2021.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Appendix summary of amendments to Agreements with DHCS
2. CMS Memorandum "CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs)"

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 14

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
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A-45 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010

A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019

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	December 7, 2017

(P&Ps) to implement California Senate Bill (SB) 1004.	

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE-MEDICAID COORDINATION OFFICE

DATE: October 7, 2019

TO: Dual Eligible Special Needs Plans

FROM: Sharon Donovan

Director, Program Alignment Group

SUBJECT: CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs)

The Bipartisan Budget Act (BBA) of 2018 permanently authorized Dual Eligible Special Needs Plans (D-SNPs), strengthened Medicare-Medicaid integration requirements, and directed the establishment of procedures to unify Medicare and Medicaid grievance and appeals procedures to the extent feasible for D-SNPs beginning in 2021. On April 16, 2019, CMS finalized rules (hereafter referred to as the April 2019 final rule) to implement these new statutory provisions.[1] This memorandum summarizes the new requirements and provides guidance to D-SNPs on the contract and operational changes needed for each type of D-SNP beginning for Contract Year (CY) 2021.

Summary of New D-SNP Requirements

We summarize the D-SNP requirements CMS codified in the April 2019 final rule below.

Integration Requirements

Starting in CY 2021, D-SNPs must meet the new Medicare-Medicaid integration criteria in at least one of the following ways:

- By meeting the requirements to be designated as a fully integrated Dual Eligible SNP (FIDE SNP), as defined at 42 CFR 422.2. A FIDE SNP is offered by the legal entity that also has a state contract as a Medicaid managed care organization (MCO) to provide Medicaid benefits, including long-term services and supports (LTSS) and behavioral health benefits, consistent with state policy; or

- By meeting the requirements to be designated as a highly integrated D-SNP (HIDE SNP), as defined at 42 CFR 422.2. A HIDE SNP covers Medicaid LTSS and/or Medicaid behavioral health benefits, consistent with state policy, under a state contract either directly with the legal entity providing the D-SNP, with the parent organization of the D-SNP, or with a subsidiary owned and controlled by the parent organization of the D-SNP; or

- By having a contract with the state specifying a process to share information with the state, or the state's designee (such as a Medicaid MCO or an area agency on aging), on

[1] See CMS-4185-F, the "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021" final rule. Retrieved from https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

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hospital and skilled nursing facility (SNF) admissions for at least one group of high-risk individuals who are enrolled in the D-SNP, as provided at 42 CFR 422.107(d).

Unified Appeals and Grievances Processes

Certain D-SNPs and affiliated Medicaid managed care plans – specifically, those with "exclusively aligned enrollment" as described in more detail in the "Unified Appeals and Grievance Requirements for FIDE SNPs and HIDE SNPs with Exclusively Aligned Enrollment" section of this memorandum – must implement unified Medicare and Medicaid grievance and plan-level appeals processes starting in CY 2021. For these plans and their enrollees, implementation of the April 2019 final rule requirements will provide simpler, more straightforward grievance and appeals processes.

State Medicaid Agency Contract and Operational Changes

All D-SNPs must have executed contracts with applicable state Medicaid agencies, referred to as the "State Medicaid Agency Contract" (SMAC), as provided under section 1859(f)(3)(D) of the Social Security Act and 42 CFR 422.107. This section of the memorandum describes the SMAC and operational changes D-SNPs must implement to operate in CY 2021 and beyond. The first subsection describes requirements that apply to all D-SNPs. Subsequent subsections describe requirements that apply only to certain subsets of D-SNPs.

Requirements for all D-SNPs

D-SNPs are required to submit by the first Monday in July a SMAC to CMS for each state in which they seek to operate for the upcoming contract year. CY 2021 contracts must be submitted to CMS by July 6, 2020. Unlike in prior years, for CY 2021, D-SNPs with an evergreen SMAC will not be able to only submit letters of good standing with a previously executed SMAC from their respective states.

The April 2019 final rule modified several existing SMAC requirements that apply to all D-SNPs and added new requirements for some D-SNPs. To comply with these requirements for CY 2021, D-SNPs will need to work with state Medicaid agencies in advance of July 2020. (See the "Key Dates for D-SNPs" section of this memorandum for more information.) The table below highlights these changes to the minimum state contract elements.

The SMAC must document:
1. ***Revised:*** The D-SNP's: (1) responsibility to coordinate the delivery of Medicaid benefits; and (2) if applicable, responsibility to provide coverage of Medicaid services.
2. ***Revised:*** The category(ies) and criteria for eligibility for dually eligible individuals to be enrolled under the D-SNP (e.g., conditions of eligibility under Medicaid, such as nursing home level of care and age or requirement for D–SNP enrollees to enroll in a companion Medicaid plan to receive their Medicaid services).
3. ***Revised:*** The Medicaid benefits covered under a capitated contract between the state Medicaid agency and the MA organization offering the D-SNP, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization.
4. The cost-sharing protections covered under the D-SNP.
5. The identification and sharing of information on Medicaid provider participation.
6. The verification of enrollees' eligibility for both Medicare and Medicaid.
7. The service area covered by the D-SNP.

The SMAC must document:
8. The contract period for the D-SNP.
9. ***New:*** For a D-SNP that is not a FIDE SNP or HIDE SNP, a requirement for notification of hospital or SNF admissions for at least one designated group of "high risk" enrollees (see the "Information Sharing Requirements for all D-SNPs except FIDE SNPs and HIDE SNPs" section of this memorandum for more information).
10. ***New:*** For a D-SNP that is an applicable integrated plan, a requirement for the use of the unified appeals and grievance procedures (see the "Unified Appeals and Grievance Requirements for FIDE SNPs and HIDE SNPs with Exclusively Aligned Enrollment" section of this memorandum for more information).

In addition to the above contract requirements, 42 CFR 422.562(a)(5), codified in the April 2019 final rule and effective beginning 2020, requires that all D-SNPs assist their enrollees with Medicaid-related grievances and address access to care issues (such as filing appeals) as part of D-SNPs' responsibility to coordinate the delivery of Medicaid benefits in 42 CFR 422.2.

Information Sharing Requirements for All D-SNPs except FIDE SNPs and HIDE SNPs

As provided under 42 CFR 422.107(d), D-SNPs that do not contract with a state as FIDE SNPs or HIDE SNPs must include the additional minimum SMAC requirement to specify a process to share information on hospital and SNF admissions starting for CY 2021. For the purpose of coordinating Medicare and Medicaid-covered services between settings of care, the SMAC must describe:

- The process whereby the D-SNP notifies, or arranges for another entity or entities to notify, the state (and/or the state's designee) of hospital and SNF admissions for at least one group of high-risk full-benefit dually eligible individuals, identified by the state;
- The timeframe and methods by which such notice is provided; and
- The group(s) of high-risk full-benefit dually eligible individuals for whom the notice is provided.

The April 2019 final rule provides flexibility to the state on the parameters of the notification process, including:

- The manner in which notification occurs and how data is exchanged;
- The recipient(s) of the notification; and
- The group of high-risk full-benefit dually eligible individuals to which the notification applies, with no requirement on minimum size.

A state and a D-SNP may arrange for other entities to perform their respective obligations with respect to the notification. A state could contract with a D-SNP such that the D-SNP meets the notification requirement by arranging for another entity – such as a hospital – to notify the state or its designees when the various parties participate in a health information exchange (HIE) or other notification system

We encourage D-SNPs to engage with states and stakeholders as soon as possible to identify the most effective approaches and processes for this notification requirement. We note some existing resources for technical assistance and best practices at the end of this memorandum.

Requirements for All FIDE SNPs and HIDE SNPs

Beginning with CY2021, CMS is establishing a new procedure for identifying a D-SNP as a FIDE SNP or HIDE SNP when fully executed SMACs are submitted to CMS on the first Monday of July 2020. MA organizations seeking to offer FIDE SNPs and HIDE SNPs must request a CMS review of the SMAC so that CMS can confirm it complies with the contract requirements for FIDE SNPs and HIDE SNPs.

Unified Appeals and Grievance Requirements for FIDE SNPs and HIDE SNPs with Exclusively Aligned Enrollment

A subset of FIDE SNPs and HIDE SNPs with exclusively aligned enrollment must implement the unified appeals and grievance procedures described in 42 CFR 422.629 – 634 beginning in 2021. In the regulations, we refer to these plans as "applicable integrated plans," defined at 42 CFR 422.561 as FIDE SNPs or HIDE SNPs with exclusively aligned enrollment, where state policy limits the D-SNP's membership to a Medicaid managed care plan offered by the same organization. (In addition, the Medicaid MCO that covers Medicaid benefits for the dually eligible individuals in the FIDE SNP or HIDE SNP with exclusively aligned enrollment is also an applicable integrated plan subect to the unified appeals and grievance procedures under 42 CFR 438.210 and 438.402.) In such plans, one organization is responsible for managing Medicare and Medicaid benefits for all D-SNP enrollees.

SMACs for these plans must include provisions that the D-SNP uses the unified appeals and grievance procedures under 42 CFR 422.629 through 422.634, as well as conforming Medicaid managed care rules at 438.210, 438.400, and 438.402. The unified appeals process includes use of a specialized integrated denial notice (*see* 42 CFR 422.631(d)) for applicable integrated plans. CMS is developing a model of this and other appeals and grievance notices and will provide opportunities for comment before finalizing them.

As specified in the April 2019 final rule, states have the discretion to implement standards different than those established in the final rule if the state standards are more protective for enrollees, such as shorter timelines for a plan to make a decision on an appeal (*see* 42 CFR 422.629(c)). The SMAC must specify any requirements where the states use this discretion to implement standards different than those in 42 CFR 422.629 through 422.634, and D-SNPs must comply with any state-specific requirements in the SMAC. States may also need to make changes to Medicaid MCO contracts for the applicable integrated plans to specify the additional requirements for unified grievances and appeals from 42 CFR 422.629 through 422.634, 438.210, 438.400, and 438.402.

Intermediate Sanctions

As provided in 42 CFR 422.752, for any D-SNP not meeting the integration criteria listed in this memorandum and specified at 42 CFR 422.2, CMS will impose, during plan years 2021 through 2025, intermediate sanctions specified at 42 CFR 422.750(a). CMS will impose intermediate sanctions specifically where CMS determines that a D-SNP fails to meet at least one of the criteria for the integration of Medicare and Medicaid benefits provided in the definition of a D-SNP at 42 CFR 422.2 and specified above.

Key Dates for D-SNPs

All D-SNPs are required to submit a new SMAC (or an evergreen SMAC with a contract addendum) to CMS for each state in which they seek to operate in for CY 2021 by Monday July 6, 2020. This includes, as applicable, the new contract requirements codified in 42 CFR 422.107(c) and (d) and summarized in this memorandum. **Therefore, we strongly encourage**

states and D-SNPs to begin discussing SMAC updates as soon as possible. The table below provides key dates and activities for states and D-SNPs related to compliance with the new requirements.

Month/Year	Activity
Fall 2019	• States and D-SNPs begin drafting changes needed to ensure SMAC meets new requirement • States plan for any needed MCO contract changes
Winter 2020	• States and D-SNPs identify and create any new policies and procedures needed in response to contract changes
January 2020	• CMS releases Contract Year 2021 MA (SNP) applications
February 2020	• SNP applications (including SNP service area expansion applications) due to CMS
Spring 2020	• States and D-SNPs finalize SMACs
June 2020	• D-SNPs not renewing MA contracts notify CMS in writing • Bid submission deadline
July 2020	• D-SNPs submit SMAC and related documents to CMS by Monday July 6, 2020
July/August 2020	• D-SNPs work with CMS and states to address deficiencies in SMACs
Summer 2020 - Fall 2020	• States and D-SNPs finalize policies and procedures for CY 2021
August/September 2020	• CMS issues SMAC status review letters and, as applicable, intermediate sanction letters • D-SNPs send Annual Notice of Change and Evidence of Coverage (including information about any changes to grievances and appeals procedures for applicable integrated plans) to current enrollees
January 1, 2021	• Effective date for most April 2019 final rule provisions

Resources

The CMS Medicare-Medicaid Coordination Office (MMCO) works across CMS and with states to better serve dually eligible individuals, including through efforts to better align the Medicare and Medicaid programs through integrated service delivery under D-SNPs. We are providing technical assistance to states to help with implementation of these new requirements through the Integrated Care Resource Center (ICRC). We believe the information for states will also be helpful to D-SNPs as they update SMACs to meet the requirements detailed in this memorandum.

Listed below are currently available resources.

- **Update on State Contracting with D-SNPs: The Basics and Meeting New Federal Requirements for 2021**
  (https://www.integratedcareresourcecenter.com/webinar/update-state-contracting-d-

snps-basics-and-meeting-new-federal-requirements-2021) provides an overview of state strategies for contracting with D-SNPs to improve care coordination and Medicare-Medicaid alignment for dually eligible enrollees. Special attention is given to new federal D-SNP integration standards for 2021 contract year, and how states can help plans to meet these requirements.

- **Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations** (https://www.integratedcareresourcecenter.com/resource/promoting-information-sharing-dual-eligible-special-needs-plans-improve-care-transitions) examines the approaches used by three states to develop and implement information-sharing processes for their D-SNPs that support care transitions. The brief includes examples of contract language and strategies to encourage plan collaboration and problem solving around information sharing. It can help states, D-SNPs, and other stakeholders assess how to meet the new D-SNP contracting requirements and improve the care of dually eligible individuals.

- **Information Sharing to Improve Care Coordination for High-Risk Dual Eligible Special Needs Plans Enrollees: Key Questions for State Implementation** https://www.integratedcareresourcecenter.com/resource/information-sharing-improve-care-coordination-high-risk-dual-eligible-special-needs-plan) offers key questions and considerations that states can review as they begin working with D-SNPs and other parties to design and implement information-sharing requirements. This technical assistance tool includes sample contract language.

Additionally, we expect ICRC to develop and disseminate sample contract language that both state and D-SNPs can use to develop their SMACs.

More Information

For any questions about the contents of this memorandum, D-SNPs should contact their account manager.

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.

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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.

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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

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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**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188
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.

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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

CalOptima
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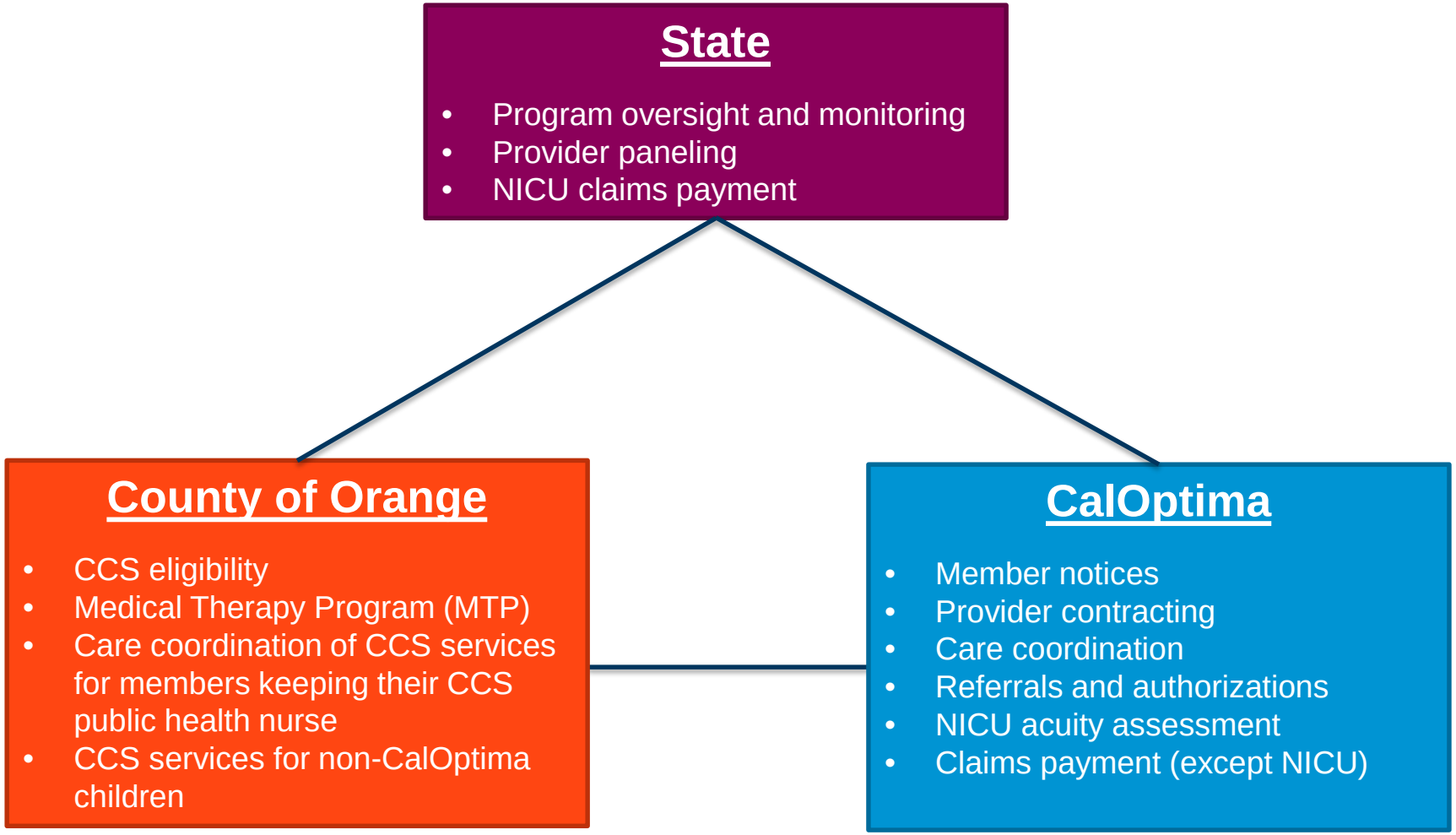
Background

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
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.

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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.

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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.

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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.

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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

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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

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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.

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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 _____

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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 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

CalOptima
A Public Agency
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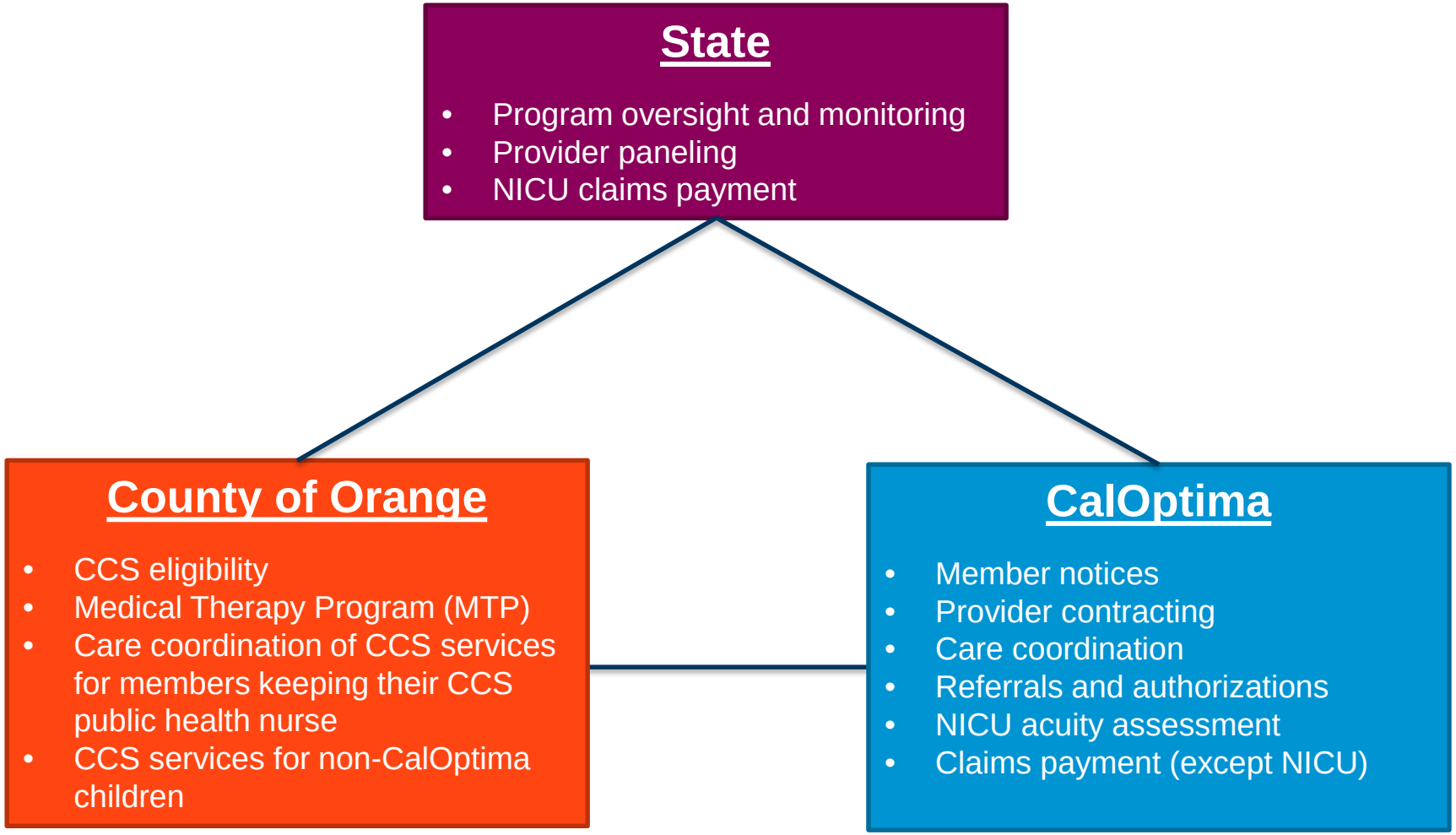
Background

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
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.

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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.

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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.

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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.

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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

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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

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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.

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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
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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 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

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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

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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

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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:

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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

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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.

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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.

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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.

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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

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IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed 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.

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Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program 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.

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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.

For 20200402 BOD Review Only

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.

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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, 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

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[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.

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[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*

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	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*

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **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

For 20200402 BOD Review Only

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.

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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 June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Authorizing Modifications to Quality Improvement Policies

Contact
David Ramirez, M.D., Chief Medical Officer, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Action(s)
1. Approve modifications to the following CalOptima policies pursuant to CalOptima's annual review process:
    a. GG.1651: Organizations Assessment and Reassessment of Organizational Providers
    b. GG.1657: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting

Background/Discussion
Modifications to Existing Quality Improvement Policies and Procedures
CalOptima regularly reviews its policies to ensure they are up to date and aligned with federal and state health care program requirements, regulatory and contractual obligations, as well as CalOptima operations.

Below are the existing Quality Improvement policies that required modifications:

- ***GG.1651: Assessment and Reassessment of Organizational Providers [Medi-Cal, OneCare, OneCare Connect, PACE]*** establishes the framework to assess Organizational Providers' (OPs') participation eligibility in the CalOptima provider network, prior to contracting and every three (3) years thereafter. Revisions include changing the reference to Health Delivery Organizations to OPs to be consistent with the National Committee for Quality Assurance, adding language specific to assessing and reassessing OPs compared with credentialing and recredentialing, removing language specific to practitioners that is not required in this policy as it is specified in GG.1650: Credentialing and Recredentialing of Practitioners, and adding the CMS Preclusion list as a disqualifying sanction list that is checked regularly. The revised policy also further describes the accreditation entities that the Plan uses for OPs.

- ***GG.1657: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting [Medi-Cal, OneCare, OneCare Connect]*** describes CalOptima's reporting requirements related to the credentialing and peer review processes imposed by the Medical Board of California (Medical Board) and the NPDB. CalOptima revised this policy pursuant to the CalOptima annual review process, and revisions include the removal of attachments and the updated list of references.

Fiscal Impact
The recommended action to approve revisions to CalOptima Policies GG.1651 and GG.1657 is operational in nature and is not expected to have a fiscal impact.

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Rationale for Recommendation

The recommended action will ensure CalOptima is compliant with contractual and regulatory guidance provided by the Plan's regulators (e.g., Department of Health Care Services and Centers for Medicare & Medicaid Services). The updated policies will supersede the prior versions.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. GG.1651: Assessment and Reassessment of Organizational Providers
2. Board Action Dated June 1, 2017 — Consider Authorizing the Chief Executive Officer (CEO) to Approve New and Revised Credentialing Policies, and to Retire Those No Longer Needed
3. GG.1657: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting
4. Board Action Dated March 7, 2019 — Consider Approval of GG.1657: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting

/s/ Richard Sanchez — *05/27/2020*

Authorized Signature — **Date**

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Policy~~#~~:	GG.1651Δ
Title:	~~Credentialing and Recredentialing of Healthcare Delivery Organizations~~Assessment and Re-Assessment of Organizational Providers
Department:	Medical ~~Affairs~~Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	06/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

For 20200604 BOD Review Only

I. PURPOSE

This policy ~~evaluates and determines whether~~establishes the framework to ~~approve or decline Healthcare Delivery Organizations (HDOs~~assess Organizational Providers' (OPs') participation eligibility in the CalOptima ~~programs~~provider network, prior to contracting and every three (3) years thereafter.

II. POLICY

A. CalOptima shall establish guidelines by which CalOptima shall evaluate and select ~~HDOs~~OPs to participate in CalOptima, in accordance with Title 42, Code of Federal Regulations, Section 422.204 and other applicable laws, regulations, and guidance.

B. CalOptima may delegate ~~Credentialing and Recredentialing activities~~the assessment and reassessment of OPs to a Health Network in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Health Network shall establish policies and procedures to ~~evaluate~~assess and ~~approve HDOs~~reassess OPs to participate in its CalOptima ~~programs~~network that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO), or his or her physician Designee, shall have direct responsibility over and actively participate in the ~~Credentialing program~~assessment and reassessment of an OP.

D. The CalOptima Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an ~~HDO's Credentialing~~OP's application information and CalOptima's findings for determining ~~such HDO's~~OP's participation in ~~CalOptima~~CalOptima's network.

E. ~~Prior to contracting with an HDO,~~ CalOptima shall require that the ~~HDO~~OP be successfully ~~credentialed, as applicable~~assessed, including ~~confirming~~confirmation that the ~~HDO~~OP is in good standing with state and federal regulatory agencies~~.~~, prior to contracting and every three (3) years thereafter

~~F. CalOptima shall categorize HDOs into three (3) risk levels: limited, moderate, and high, for committing Fraud, Waste and Abuse, and will screen HDOs for the appropriate risk level in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 17-019:~~

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~~Provider Credentialing /Recredentialing and Screening / Enrollment, Title 42, CFR, Section 455, and as described Section III.A. of this Policy.~~

F. CalOptima shall require OPs to be reviewed and approved by an accrediting body or received an on-site quality assessment consistent with the provisions of this Policy if the provider is not accredited, as applicable.

G. CalOptima shall ~~Recredential an HDO at least every three (3) years, utilizing a thirty-six (36) month cycle to the month, not to~~ensure that the ~~day.~~OP is actively enrolled in Medi-Cal, as applicable.

~~G.~~H. On a monthly basis, CalOptima shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG~~,~~) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM~~,~~), CMS Preclusion List and Medi-Cal~~.~~ Suspended & Ineligible (S&I). CalOptima shall immediately suspend any ~~HDO~~OP identified on the sanction lists in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse ~~Activities~~Actions.

~~H.~~I. If CalOptima declines to include an ~~HDO~~OP in the CalOptima network, CalOptima shall notify, in writing, such ~~HDO~~OP within sixty (60) calendar days of the reason for its decision. An ~~HDO~~OP shall have the right to file a complaint about the decision in accordance with CalOptima Policies HH.1101: CalOptima Provider Compliant and MA.9006: Provider Complaint Process, as applicable.

~~I.~~ CalOptima shall ~~monitor and prevent discriminatory Credentialing decisions as follows:~~

~~1. Periodic audits of Credentialing files (in process, denied, and approved files) to ensure providers are not discriminated against;~~

~~2. Periodic audits of HDO complaints to determine if there are complaints alleging discrimination, including a review by the CPRC of quarterly reports of complaints, including discrimination;~~

~~3. Maintaining a heterogeneous Credentialing committee membership; and~~

~~4. Requiring that those responsible for Credentialing and Recredentialing decisions sign a statement affirming that they do not discriminate when making decisions.~~

J. ~~CalOptima shall~~ maintain the confidentiality of ~~Credentialing~~credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

K. ~~On an annual basis, the~~The CalOptima Board of Directors shall review and approve this Policy periodically.

III. PROCEDURE

A. ~~HDO~~OP Initial ~~Credentialing~~Assessment

1. ~~Prior~~Upon notification of an intent to ~~contracting with a Medical HDO~~contract, CalOptima shall ~~initiate the Credentialing process and~~ confirm ~~that~~ the ~~Medical HDO~~OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section II.H. of this Policy.

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2. The ~~HDO~~OP shall submit ~~a~~an application, signed and dated ~~application and include~~by an authorized official of the OP, along with the following ~~attachments~~supplemental documentation:

   a. ~~A current, valid license to operate in California, and confirmation that the HDO~~Confirmation that the OP is in compliance with any other applicable state or federal ~~requirement~~requirements, and~~/or~~ possess a business license (or business tax certificate), as applicable;

   b. Accreditation ~~certificate~~and/or Government Issued Certification, as applicable. ~~Accrediting~~Issuing bodies include, but are not limited to:

      i. The Joint Commission~~:~~ (TJC): A copy of the certificate of accreditation by the Joint Commission, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

      ii. Accreditation Association for Ambulatory Health Care (AAAHC~~);~~) for outpatient settings including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

      iii. Commission on Accreditation of Rehabilitation Facilities (CARF~~);~~) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, prosthetics and orthotics supplies, and opioid treatment programs;

      iv. Community Health Accreditation Program (CHAP~~);~~) for home health agencies, hospice providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

      ~~v. Continuing Care Accreditation Commission (CCAC); and~~

      ~~vi. Clinical Laboratory Improvement Amendments (CLIA).~~

      v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

      vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing and audiology certification;

      vii. Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS);

      viii. Commission on accreditation of ambulance services (CAAS) for ambulance organizations;

      ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

      x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, Durable Medical Equipment prosthetics orthotic suppliers, pharmacies; and

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xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging providers, and procedure-based modalities.

~~c.~~ If an ~~HDO~~OP is not accredited, the ~~HDO~~OP may submit evidence of an ~~onsite~~on-site quality review by the state, CMS, or similar agency, or CalOptima must provide evidence of ~~onsite~~on-site quality review. ~~-~~The ~~onsite~~on-site quality review must include the criteria used for the assessment, and the process for ensuring that the providers ~~Credential~~credential their Practitioners.

~~d.~~c. The State, CMS, or a similar agency, quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima shall conduct its own ~~on-site~~onsite quality review.

~~e.~~d. Certificate of current liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as ~~follows~~applicable:

i. General/Commercial Liability Insurance;

~~i.~~ii. Professional liability ~~at one million ($1,000,000) per occurrence and three million ($3,000,000) aggregate; and~~;

~~ii. Non-facilities liability at one million ($1,000,000) per occurrence and two million ($2,000,000) aggregate;~~

iii. Worker's Compensation Insurance.

~~f.~~e. A copy of any history of sanctions ~~or~~ , preclusions, exclusions, suspensions or terminations from Medicare and/or Medi-Cal~~; providers terminated from either Medicare or Medi-Cal or on the Suspended and Ineligible Provider list~~, as applicable.

~~g.~~f. Active enrollment in Medi-Cal ~~and Medicare and a copy of exemptions,~~ if applicable;

~~h.~~g. A copy of the organization's Quality ~~Programs~~Plan, if applicable;

~~i.~~h. Staff roster and copy of all staff certifications, or licensure, if applicable;

i. A valid Type 2 National Provider Identifier (NPI) number;

j. IRS Form SS-4, if applicable; and

k. A current W-9.

3. CalOptima shall conduct and communicate the results of a Facility Site Review (FSR) for Community Clinics and Free Standing Urgent Care centers providing services to CalOptima Members pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews to incorporate the documents to support review prior to ~~Credentialing~~approval decisions.

4. All ~~Credentialing~~participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

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~~5. HDO Screening~~

~~a. If CalOptima identifies an HDO as moderate or high risk, CalOptima will conduct a pre-enrollment site visit prior to contracting.~~

B. ~~If CalOptima identifies an HDO as high risk,~~ OP Re-assessment

~~b.~~ CalOptima shall ~~also require verification of a completed criminal background check and fingerprinting for prospective (newly credentialed) home health agencies and suppliers of Durable Medical Equipment and prosthetic and orthotic supplies and any individual with a five percent (5%), or greater, ownership.~~

~~B. HDO Recredentialing~~

1. ~~CalOptima shall Recredential a Medical or Service HDO~~reassess an OP at least every three (3) years after initial ~~Credentialing.~~assessment. At the time of ~~Recredentialing~~re-assessment, CalOptima shall:

   a. Collect and verify, at a minimum, all of the information required for initial ~~credentialing~~assessment, as set forth in Section III.A. of this Policy; and

   b. Incorporate the following data in the decision-making process:

      i. Quality review activities, including but not limited to, information from:

         a) DHCS, CMS, or another agency, as applicable;

         b) CalOptima quality review results, ~~as applicable;~~including, but not limited to, Grievances, Appeals, Potential Quality Issue (PQI) cases, and Compliance cases, as applicable;

         c) Review of Facility Site Review (FSR) or Physical Accessibility Review Survey (PARS) results, as applicable; and

         ~~d) Review of Grievance, Appeal, and potential quality issue (PQI) case reviews.~~

      ~~ii. Review of the HDO's compliance with the terms of its contract with CalOptima.~~

      ~~a)~~d)~~Member satisfaction, if~~Medical Records, as applicable~~;~~.

      iii. ~~Medical Record Reviews~~Member experience, if applicable;

      iv. ~~FSR results and Physical Accessibility Review Survey (PARS) results~~Liability claims history, if applicable; and

      v. Compliance with the terms of the Provider's contract.

2. CalOptima shall ensure that an ~~HDO~~OP has current ~~California~~appropriate licensure, accreditation (if applicable), and insurance at all times during such ~~HDO's~~OP's participation in CalOptima.

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~~3. If CalOptima terminates an HDO during the Recredentialing process for administrative reasons (e.g., the HDO failed to provide complete credentialing information) and not for quality reasons, it may reinstate the HDO within thirty (30) calendar days of termination and is not required to perform initial credentialing. However, CalOptima must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima must perform initial Credentialing of such HDO.~~

~~4. All Recredentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.~~

~~C. HDO Rights~~

~~1. CalOptima shall maintain Credentialing files that include documentation of required elements, as described in this Policy.~~

~~2. An HDO shall have the right to file a complaint about the decision in accordance with CalOptima Policies HH.1101: CalOptima Provider Compliant and MA.9006: Provider Complaint Process, as applicable.~~

C. Credentialing Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding ~~Credentialing and Recredentialing~~CalOptima's provider network.

2. Completed ~~Credentialing and Recredentialing~~OP files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

   a. A clean file consists of a complete signed application ~~with a signed attestation and consent form,~~, required supporting documents that are current and valid, and verification ~~of~~ there have been no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the ~~HDO~~OP within the last seven (7) years from the date of the ~~Credentialing or Recredentialing review~~assessment has occurred, and confirmation that the OP is in good standing with state and federal regulatory agencies.

      i. A clean file shall be considered approved and effective on the date that the CMO, or his or her physician Designee, review and approve ~~a HDO's Credentialing or Recredentialing~~an OP's assessment and re-assessment file, and deem the file clean.

      ii. Approved, clean file lists shall be presented at the CPRC and reflected in the meeting minutes.

   b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the ~~HDO, or files of HDOs that have a history of being included on the Medi-Cal Suspended and Ineligible Provider List~~OP.

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i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the ~~Provider~~provider submits all the required information.

ii. CPRC minutes shall reflect thoughtful consideration of information presented in the ~~credentialing~~ file.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

3. The CPRC shall make recommendations based on the ~~HDO's~~OP's ability to deliver ~~care~~services based on the ~~Credentialing~~ information collected from the file review process.

a. The CalOptima Quality Improvement Department shall send the ~~HDO~~OP, or applicant, a decision letter, within sixty (60) calendar days of the Initial decision:

i. Acceptance;

~~ii. Approved with Restrictions; or~~

~~iii.~~ii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

~~b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.~~

~~c. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any HDO, during the HDO's Credentialing, or Recredentialing process, the application shall be considered expired.~~

4. Upon acceptance of the ~~Credentialing~~participation application, the CalOptima Quality Improvement Department shall generate a ~~Provider~~provider profile and forward the ~~Provider~~provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and ~~Credentialing~~provider data into CalOptima's core business system, which updates pertinent information into the online Provider ~~directory~~Directory.

IV. ATTACHMENTS

~~A. Ongoing Monitoring Website Information Matrix~~
A. ~~On Site~~Organizational Provider Application
~~A.~~B. ~~On Site~~ Quality Review Tool

V. REFERENCES

~~O. California Evidence Code, §1157~~
A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal

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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 GG.1604Δ: Confidentiality of Credentialing Files
~~F.~~G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
~~G.~~H. CalOptima Policy GG.1607Δ: Monitoring Adverse ~~Activities~~Actions
~~H.~~I. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
~~I.~~J. CalOptima Policy HH.1101: CalOptima Provider Compliant
~~J.~~K. CalOptima Policy MA.9006: Provider Complaint Process
~~K. A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~

N. Department of Health Care Services All Plan Letter (APL) ~~17-019~~19-004: Provider Credentialing / Recredentialing and Screening / Enrollment
O. California Evidence Code, §1157
P. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 424, 431 and 455.450
Q. Title 45, Code of Federal Regulations, §455
R. Title 42, United States Code, §1320a-7(a)
S. Title XVIII and XIV of the Social Security Act
T. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors

~~A. 06/01/17: Regular Meeting of the CalOptima Board of Directors~~

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651Δ	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1651Δ	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	A request by the Member or the Member's Authorized Representative for review of any decision to deny, modify, or discontinue a Covered Service.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a provider to provide quality and safe patient care services.
Credentialing Peer Review Committee	Peer review body who reviews provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Durable Medical Equipment (DME)	Durable medical equipment means equipment prescribed by a licensed practitioner to meet 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 an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Facility Site Review	An ~~onsite~~on-site inspection of primary care sites to evaluate the capacity or continuing capacity of a site to support the delivery of quality health care services using the DHCS Facility Site Review (FSR), Medical Record Review (MRR) or Physical Accessibility Review Survey (PARS~~), DHCS provided~~) tools.
Grievance	An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.
Health Network	A Physician Hospital Consortium (PHC), ~~Physician Medical Group,~~ physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that ~~Health Network.~~health network.
~~Medical Health Delivery Organizations (HDOs)~~	~~Organizations that are contracted to provide medical services such as hospitals, home health agencies, skilled nursing facilities, free standing surgical centers, extended care facilities (LTC), nursing homes (assisted living), hospice, community clinic, urgent care centers, dialysis centers, Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, rehabilitation facilities.~~
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An enrollee-beneficiary of a CalOptima program.
Organizational Provider	Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient

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Term	Definition
	physical therapy and speech pathology providers, diabetes centers, and portable x-ray suppliers.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers
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	Any person or institution that furnishes Covered Services.
~~Recredentialing~~Re-Assessment	The process by which provider ~~qualifications or~~ status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
~~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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CalOptima
A Public Agency
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Applicant Tax ID:_____

Organizational Provider (OP)
Quality Assessment Application
and Survey of Specialties and Services

The following application is for organizations which intend to contract with CalOptima. Upon approval, organization then becomes eligible contract should CalOptima be in need of the provider type or services organization provides. Please complete application as accurately and completely as possible. Inclomplete applications will not be accepted. In the event organization is assigned with either a moderate or high risk level, CalOptima may perform an on-site visit.

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Name of Organization:			
DBA (If Applicable):			
Billing NPI:		**Tax ID:**	
Business Type:	[ ] LLC	[ ] Corporation	[ ] LP

Line of Business Intended to Contract as:

[ ] CalMediConnect	[ ] Medi-Cal	[ ] OneCare
CalOptima Program(s)	[ ] Behavioral Health	[ ] PACE	[ ] MSSP / IHSS

Registrations and Enrollment

Type	ID	Effective Date	Type/Specialty
Medi-Cal Registration/Enrollment			
Medicare Registration/Enrollment			
Medicare (CMS) Certification			
DHCS/California Licensure			
California Children's Services			

Primary Specialty: _____ *select from one listed in 'Organization Specialty" section below*

Organization Type:

[ ] Agency	[ ] Laboratory	[ ] Respite Care
[ ] Ambulatory Care Facility	[ ] Practitioner/Physician Group	[ ] Supplier
[ ] Hospital	[ ] Nursing & Custodial Care Facility	[ ] Transportation Services
[ ] Hospital Unit	[ ] Residential Treatment Facility	[ ] Other

Count of Accreditations Held _____ **Count of Service Addresses** _____

Business/Administrative Information

Business Address

Street **Suite/Unit #** **City** **State** **Zip**

Phone **Fax**

Business License / Tax Certificate Issued By:

Billing Address

[ ] *Billing is performed by a third party. If so, indicate company name*_____

Street **Suite/Unit #** **City** **State** **Zip**

Phone **Fax**

Mailing Address

[ ] *Mailing address is the same as the business address*

Street **Suite/Unit #** **City** **State** **Zip**

Phone **Fax**

Organization's Authorized Official(s)

Authorized Official Name			
Title			
Email Address		**Contact Phone**	

If applicable to applicant organization, supply the below contact information. **Please note CalOptima uses email as the primary method for communication.** If a similar role is held by your organization, please enter the individuals information.

	Name	Email Address
Practitioner Credentialing Contact		
CEO *(Chief Executive Officer)*		
CAO *(Chief Administration Officer)*		
CMO *(Chief Medical Officer)*		
CFO *(Chief Financial Officer)*		
Director of Nursing		

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Applicant Tax ID:_____

Organization Accreditation or Government Issued Certification *(If more than one is held, complete page 3 for each held)*

Accrediting/Certifying Body	
Identification Number	

[ ] Check if on-site visit was performed

Last Survey Date	
Next Survey Date	

Check all which apply below, as it applies to the organization's accreditation or Certification. Data will be used to assist with Member Referrals and Authorizations

Administration

- [ ] Case Management (CM)
- [ ] Credentialing/Staffing (CR)
- [ ] Patient Safety/Plan (PS)
- [ ] Quality Improvement/Plan (QI)
- [ ] Utilization Management (UM)

Programs/Services

- [ ] Ambulatory Care
- [ ] Ambulatory Surgery
- [ ] Anesthesia
- [ ] Aquatic Therapy
- [ ] Behavioral Health
- [ ] Behavioral Health (Home)
- [ ] Canes and Crutches
- [ ] Chronic Kidney Disease
- [ ] Chronic Obstructive Pulmonary Disease
- [ ] Community Integration
- [ ] Comprehensive Cardiac Center
- [ ] Convenient Care
- [ ] CT Scanner
- [ ] Custom Othoses Fabricated
- [ ] Dementia Care
- [ ] Dentistry
- [ ] Diabetes Self Management
- [ ] Diagnostic Imaging
- [ ] Dialysis
- [ ] Donor Center / Testing
- [ ] Durable Medical Equipment
- [ ] EEG/EKG/FMG Lab
- [ ] Emergency Medicine/Department
- [ ] Enteral Nutrients
- [ ] Gastroenterology
- [ ] Gynecology
- [ ] Heart Failure
- [ ] Heart Failure
- [ ] Hip and Knee Replacement

Programs/Services, cont.

- [ ] Home Care
- [ ] Home Health (Aides)
- [ ] Home Health (Non-Hospice)
- [ ] Hospital
- [ ] Hospital (Critical Access)
- [ ] Hospital (Pediatric)
- [ ] Hospital (Psychiatric)
- [ ] Hospital Beds - Electric
- [ ] Hospital Beds - Manual
- [ ] Immunohematology
- [ ] Inpatient Diabetes
- [ ] Inpatient Unit
- [ ] Laboratory (General)
- [ ] Lung Volume Reduction Surgery
- [ ] Magnetic Resonance Imaging (MRI)
- [ ] Medical/Surgical Unit
- [ ] Molecular Testing
- [ ] Nebulizers Equipment
- [ ] Nursing Care
- [ ] Obstetrics
- [ ] Occupational Therapy
- [ ] Office Based Surgery
- [ ] Orthopedic Surgery
- [ ] Out of Hospital Transfusion Administra
- [ ] Out Patient Clinic
- [ ] Trigger Point Injections
- [ ] Palliative Care
- [ ] Palliative Care (Community Based)
- [ ] Patient Lists and Accessories
- [ ] Pediatric Medicine
- [ ] Perform Invasive Procedure
- [ ] Perinatal Care
- [ ] Perioperative Service
- [ ] Personal Care/Support (Non-Hospice)
- [ ] Pharmacy/Dispensary (General)

Programs/Services, cont.

- [ ] Physical Therapy
- [ ] Plastic Surgery
- [ ] Post-Acute Care
- [ ] Primary Care Medical
- [ ] Primary Stroke Center
- [ ] Rehabilitation Services
- [ ] Respiratory Equipment
- [ ] Skilled Nursing (Care)
- [ ] Skilled Nursing (Services)
- [ ] Social Services
- [ ] Social Services (Medical)
- [ ] Speech Language Pathology
- [ ] Stroke (Advance)
- [ ] Stroke (Comprehensive)
- [ ] Supplies
- [ ] Support Surfaces for Beds
- [ ] Thrombectomy-Capable Stroke Center
- [ ] Transfusion Service
- [ ] Ultrasound
- [ ] Ventricular Assist Device
- [ ] Walkers, Canes and Crushes
- [ ] Wheelchairs - Manual (Non-Custom)
- [ ] X-ray
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____

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Organizational Specialties

( ) Single-specialty ( ) Multi-specialty

Please identify all specialties below which apply to applicant organization in which intentions are to either contract or submit claims for. Additionally, for each identified specialty, also identify if either an accreditation, certification and/or license is held by the applicant for the specialty.

Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
	Agencies			
[ ]	Case Management	251B00000X	[ ]	[ ]
[ ]	Day Training, Developmentally Disabled Services	251C00000X	[ ]	[ ]
[ ]	Home Health	251E00000X	[ ]	[ ]
[ ]	Home Health (subunit)	251E00000X	[ ]	[ ]
[ ]	Home Infusion	251F00000X	[ ]	[ ]
[ ]	Hospice Care, Community Based	251G00000X	[ ]	[ ]
[ ]	Nursing Care	251J00000X	[ ]	[ ]
[ ]	Public Health or Welfare	251K00000X	[ ]	[ ]
[ ]	Community/Behavioral Health	251S00000X	[ ]	[ ]
[ ]	Program of All-Inclusive Care for the Elderly (PACE) Provider Organization	251T00000X	[ ]	[ ]
[ ]	Voluntary or Charitable	251V00000X	[ ]	[ ]
[ ]	Early Intervention Provider Agency	252Y00000X	[ ]	[ ]
[ ]	In Home Supportive Care	253Z00000X	[ ]	[ ]
	Ambulatory Health Care Facilities [Clinic/Center]			
[ ]	Ambulatory Family Planning Facility	261QA0005X	[ ]	[ ]
[ ]	Adult Day Care	261QA0600X	[ ]	[ ]
[ ]	Ambulatory Surgical	261QA1903X	[ ]	[ ]
[ ]	Birthing	261QB0400X	[ ]	[ ]
[ ]	Critical Access Hospital	261QC0050X	[ ]	[ ]
[ ]	Community Health	261QC1500X	[ ]	[ ]
[ ]	Corporate Health	261QC1800X	[ ]	[ ]
[ ]	Dental	261QD0000X	[ ]	[ ]
[ ]	Developmental Disabilities	261QD1600X	[ ]	[ ]
[ ]	Emergency Care	261QE0002X	[ ]	[ ]
[ ]	End-Stage Renal Disease (ESRD) Treatment	261QE0700X	[ ]	[ ]
[ ]	Endoscopy	261QE0800X	[ ]	[ ]
[ ]	Family Planning, Non-Surgical	261QF0050X	[ ]	[ ]
[ ]	Federally Qualified Health Center (FQHC)	261QF0400X	[ ]	[ ]
[ ]	Genetics	261QG0250X	[ ]	[ ]
[ ]	Health Service	261QH0100X	[ ]	[ ]
[ ]	Hearing and Speech	261QH0700X	[ ]	[ ]
[ ]	Infusion Therapy	261QI0500X	[ ]	[ ]
[ ]	Mental Health (Including Community Mental Health Center)	261QM0801X	[ ]	[ ]
[ ]	Adult Mental Health	261QM0850X	[ ]	[ ]
[ ]	Adolescent and Children Mental Health	261QM0855X	[ ]	[ ]
[ ]	Migrant Health	261QM1000X	[ ]	[ ]
[ ]	Magnetic Resonance Imaging (MRI)	261QM1200X	[ ]	[ ]

For 20200604 BOD Review Only

Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
Ambulatory Health Care Facilities [Clinic/Center] (cont.)				
[ ]	Medical Specialty	261QM2500X	[ ]	[ ]
[ ]	Methadone	261QM2800X	[ ]	[ ]
[ ]	Podiatric	261QP1100X	[ ]	[ ]
[ ]	Physical Therapy	261QP2000X	[ ]	[ ]
[ ]	Primary Care	261QP2300X	[ ]	[ ]
[ ]	Pain	261QP3300X	[ ]	[ ]
[ ]	Radiology	261QR0200X	[ ]	[ ]
[ ]	Radiology, Mammography	261QR0206X	[ ]	[ ]
[ ]	Radiology, Mobile Mammography	261QR0207X	[ ]	[ ]
[ ]	Radiology, Mobile	261QR0208X	[ ]	[ ]
[ ]	Outpatient Rehabilitation (mixed specialty - OT,PT,SLP)	261QR0400X	[ ]	[ ]
[ ]	Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	261QR0401X	[ ]	[ ]
[ ]	Rehabilitation, Cardiac Facilities	261QR0404X	[ ]	[ ]
[ ]	Rehabilitation, Substance Use Disorder	261QR0405X	[ ]	[ ]
[ ]	Research	261QR1100X	[ ]	[ ]
[ ]	Rural Health	261QR1300X	[ ]	[ ]
[ ]	Oral and Maxillofacial Surgery	261QS0112X	[ ]	[ ]
[ ]	Ophthalmologic Surgery	261QS0132X	[ ]	[ ]
[ ]	Sleep Disorder Diagnostic	261QS1200X	[ ]	[ ]
[ ]	Urgent Care	261QU0200X	[ ]	[ ]
[ ]	Occupational Medicine	261QX0100X	[ ]	[ ]
[ ]	Oncology	261QX0200X	[ ]	[ ]
[ ]	Oncology, Radiation	261QX0203X	[ ]	[ ]
[ ]	Optometry	152W00000X	[ ]	[ ]
Hospitals				
[ ]	Chronic Disease Hospital	281P00000X	[ ]	[ ]
[ ]	Chronic Disease Hospital [Pediatric]	281PC2000X	[ ]	[ ]
[ ]	Long Term Care Hospital	282E00000X	[ ]	[ ]
[ ]	General Acute Care Hospital	282N00000X	[ ]	[ ]
[ ]	General Acute Care Hospital [Critical Care]	282NC0060X	[ ]	[ ]
[ ]	General Acute Care Hospital [Pediatric]	282NC2000X	[ ]	[ ]
[ ]	General Acute Care Hospital [Rual]	282NR1301X	[ ]	[ ]
[ ]	General Acute Care Hospital [Women's]	282NW0100X	[ ]	[ ]
[ ]	Psychiatric Hospital	283Q00000X	[ ]	[ ]
[ ]	Rehabilitation Hospital	283X00000X	[ ]	[ ]
[ ]	Rehabilitation Hospital [Pediatric]	283XC2000X	[ ]	[ ]
[ ]	Religious Non-Medical Health Care Institution	282J00000X	[ ]	[ ]
[ ]	Special Hospital	284300000X	[ ]	[ ]
[ ]	Military Hospital	286500000X	[ ]	[ ]
[ ]	Military Hospital [General Acute Care Hospital]	2865M2000X	[ ]	[ ]

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Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
	Hospital Units			
[ ]	Epilepsy Unit	273100000X	[ ]	[ ]
[ ]	Psychiatric Unit	273R00000X	[ ]	[ ]
[ ]	Rehabilitation Unit	273Y00000X	[ ]	[ ]
[ ]	Medicare Defined Swing Bed Unit	275N00000X	[ ]	[ ]
[ ]	Rehabilitation, Substance Use Disorder Unit	276400000X	[ ]	[ ]
	Laboratories			
[ ]	Military Clinical Medical Laboratory	291900000X	[ ]	[ ]
[ ]	Clinical Medical Laboratory	291U00000X	[ ]	[ ]
[ ]	Dental Laboratory	292200000X	[ ]	[ ]
[ ]	Physiological Laboratory	293D00000X	[ ]	[ ]
	Organizations			
[ ]	Exclusive Provider Organization	302F00000X	[ ]	[ ]
[ ]	Health Maintenance Organization	302R00000X	[ ]	[ ]
[ ]	Preferred Provider Organization	305R00000X	[ ]	[ ]
[ ]	Point of Service	305S00000X	[ ]	[ ]
	Nursing & Custodial Care Facilities			
[ ]	Assisted Living Facility	310400000X	[ ]	[ ]
[ ]	Intermediate Care Facility, Mental Illness	310500000X	[ ]	[ ]
[ ]	Alzheimer Center (Dementia Center)	311500000X	[ ]	[ ]
[ ]	Custodial Care Facility	311Z00000X	[ ]	[ ]
[ ]	Custodial Care Facility [Adult Care Home]	311ZA0620X	[ ]	[ ]
[ ]	Nursing Facility/Intermediate Care Facility	313M00000X	[ ]	[ ]
[ ]	Skilled Nursing Facility	314000000X	[ ]	[ ]
[ ]	Skilled Nursing Facility [Pediatric]	3140N1450X	[ ]	[ ]
[ ]	Hospice, Inpatient	315D00000X	[ ]	[ ]
[ ]	Intermediate Care Facility, Mentally Retarded	315P00000X	[ ]	[ ]
	Residential Treatment Facilities			
[ ]	Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities	320600000X	[ ]	[ ]
[ ]	Residential Treatment Facility, Physical Disabilities	320700000X	[ ]	[ ]
[ ]	Community Based Residential Treatment Facility, Mental Illness	320800000X	[ ]	[ ]
[ ]	Community Based Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities	320900000X	[ ]	[ ]
[ ]	Residential Treatment Facility, Emotionally Disturbed Children	322D00000X	[ ]	[ ]
[ ]	Psychiatric Residential Treatment Facility	323P00000X	[ ]	[ ]
[ ]	Substance Abuse Rehabilitation Facility	324500000X	[ ]	[ ]
[ ]	Substance Abuse Rehabilitation Facility [Pediatric]	3245S0500X	[ ]	[ ]
	Respite Care Facility			
[ ]	Respite Care	385H00000X	[ ]	[ ]

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Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
	Suppliers			
[ ]	Blood Bank	331L00000X	[ ]	[ ]
[ ]	Military/U.S. Coast Guard Pharmacy	332000000X	[ ]	[ ]
[ ]	Department of Veterans Affairs (VA) Pharmacy	332100000X	[ ]	[ ]
[ ]	Non-Pharmacy Dispensing Site	332900000X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies	332B00000X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Customized Equipment]	332BC3200X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Dialysis Equipment]	332BD1200X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Nursing Facility Supplies]	332BN1400X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Perenteral & Enteral Nutrition]	332BP3500X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies [Oxygen Equipment & Supplies]	332BX2000X	[ ]	[ ]
[ ]	Eyewear Supplier	332H00000X	[ ]	[ ]
[ ]	Hearing Aid Equipment	332S00000X	[ ]	[ ]
[ ]	Home Delivered Meals	332U00000X	[ ]	[ ]
[ ]	Emergency Response System Companies	333300000X	[ ]	[ ]
[ ]	Pharmacy	333600000X	[ ]	[ ]
[ ]	Pharmacy[Clinic Pharmacy]	3336C0002X	[ ]	[ ]
[ ]	Pharmacy[Community Retail]	3336C0003X	[ ]	[ ]
[ ]	Pharmacy[Compounding Pharmacy]	3336C0004X	[ ]	[ ]
[ ]	Pharmacy[Home Infusion Therapy Pharmacy]	3336H0001X	[ ]	[ ]
[ ]	Pharmacy[Institutional Pharmacy]	3336I0012X	[ ]	[ ]
[ ]	Pharmacy[Long Term Care Pharmacy]	3336L0003X	[ ]	[ ]
[ ]	Pharmacy[Mail Order Pharmacy]	3336M0002X	[ ]	[ ]
[ ]	Pharmacy[Managed Care Organization Pharmacy]	3336M0003X	[ ]	[ ]
[ ]	Pharmacy[Nuclear Pharmacy]	3336N0007X	[ ]	[ ]
[ ]	Pharmacy[Specialty Pharmacy]	3336S0011X	[ ]	[ ]
[ ]	Prosthetic/Orthotic Supplier	335E00000X	[ ]	[ ]
[ ]	Medical Foods Supplier	335G00000X	[ ]	[ ]
[ ]	Organ Procurement Organization	335U00000X	[ ]	[ ]
[ ]	Portable X-ray and/or Other Portable Diagnostic Imaging Supplier	335V00000X	[ ]	[ ]
	Transportation Services			
[ ]	Ambulance [Air Transport]	3416A0800X	[ ]	[ ]
[ ]	Ambulance [Land Transport]	3416L0300X	[ ]	[ ]
[ ]	Ambulance [Water Transport]	3416S0300X	[ ]	[ ]
[ ]	Military/U.S. Coast Guard Transport	341800000X	[ ]	[ ]
[ ]	Secured Medical Transport (VAN)	343800000X	[ ]	[ ]
[ ]	Non-emergency Medical Transport (VAN)	343900000X	[ ]	[ ]
[ ]	Transportation Broker	347E00000X	[ ]	[ ]

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If specialty is not found in this section please provide the following:

	Specialty	Taxonomy Code *(if known)*
Primary Specialty		
Specialty 2		
Specialty 3		
Specialty 4		
Specialty 5		
Specialty 6		

Section intentionally left blank

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Applicant Tax ID:_____

Service Address(es)	Location 1 of _____

[ ] Check if location is included in organization's accreditation

Address Type(s) [ ] After hours [ ] Service Address [ ] Unit

If applicable, alternate location name

Location NPI

Street **Suite/Unit#** **City** **State** **Zip**

Member Access Phone

Member Fax

Admit Address for After Hours? ☐ YES ☐ NO

After Hours Phone Number

Website URL:

Administrative Contact for Location

Name Phone Email

Hours of Operation: [ ] Check if open 24/7

☐ Including holidays ☐ Excluding holidays

		SUN	MON	TUE	WED	THU	FRI	SAT
AM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:
PM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:

Ages Served

[ ] Peri-Natal [ ] Child [ ] Adult

[ ] Infant [ ] Adolescent [ ] Geriatric

Languages Spoken

Enter all languages spoken by Member facing staff

Special Services at Location

☐ Location is Enrolled in Medi-Cal ☐ Telehealth Distant Site

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Applicant Tax ID:_____

Service Address(es)	**Location 2 of _____**

[ ] Check if location is included in organization's accreditation

Address Type(s) **[ ] After hours** **[ ] Service Address** **[ ] Unit**

If applicable, alternate location name	
Location/Unit NPI	

Street **Suite/Unit#** **City** **State** **Zip**

Member Access Phone

Member Fax

Admit Address for After Hours? ☐ YES ☐ NO

After Hours Phone Number

Website URL:

Administrative Contact for Location

Name Phone Email

Hours of Operation: **[ ] Check if open 24/7**

☐ Including holidays ☐ Excluding holidays

		SUN	MON	TUE	WED	THU	FRI	SAT
AM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:
PM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:

Ages Served			
	[ ] Peri-Natal	**[ ] Child**	**[ ] Adult**
	[ ] Infant	**[ ] Adolescent**	**[ ] Geriatric**

Languages Spoken

Enter all languages spoken by member facing staff

Special Services at Location

☐ Location is Enrolled in Medi-Cal ☐ Telehealth Distant Site

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Applicant Tax ID:_____

Service Address(es) | **Location 3 of _____**

[ ] Check if location is included in organization's accreditation

Address Type(s) [ ] After hours [ ] Service Address [ ] Unit

If applicable, alternate location name

Location NPI

Street **Suite/Unit#** **City** **State** **Zip**

Member Access Phone

Member Fax

Admit Address for After Hours? ☐ YES ☐ NO

After Hours Phone Number

Website URL:

Administrative Contact for Location

Name **Phone** **Email**

Hours of Operation [ ] Check if open 24/7

☐ Including holidays ☐ Excluding holidays

		SUN	MON	TUE	WED	THU	FRI	SAT
AM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:
PM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:

Ages Served

[ ] Peri-Natal [ ] Child [ ] Adult

[ ] Infant [ ] Adolescent [ ] Geriatric

Languages Spoken

Enter all languages spoken by member facing staff

Special Services at Location

☐ Location is Enrolled in Medi-Cal ☐ Telehealth Distant Site

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Attestation

I attest that all of the information submitted by me in this document is true, correct, and complete to the best of my knowledge and belief. I understand that any significant misstatements in, or omissions from, this application may constitute cause for denial of participation or cause for summary dismissal from CalOptima or be subject to applicable State or Federal penalties for perjury. I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

You and your agents must meet CalOptima's Eligibility Status requirements. This means that you and your agents must be eligible to participate in Federal and/or State healthcare programs, including the Medi-Cal Program (not currently suspended, excluded or otherwise ineligible and not excluded at any time based on a mandatory exclusion in 42 U.S.C. 1396a-7(a), hold appropriate government issued licensures, not held liable in any criminal or civil proceedings for fraud waste or abuse and not convicted of a criminal offense related to healthcare in the prior seven (7) years).

Persons or entities that do not meet the Eligibility Status requirements are not eligible to receive reimbursement from CalOptima. As referred to in this application which also serves as CalOptima's registration form, "your agents" means all of your employees, subcontractors, and/or agents furnishing items or services to CalOptima and its members.

You and your agents must comply with any executed contracts with CalOptima, CalOptima's Compliance Program, all CalOptima Policies and Procedures applicable to items and/or services you furnish to CalOptima and its members.

Name of Authorized Official

Title of Authorized Official

Signature of Authorized Official

Date

Email Address

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Submit completed application and supplemental documents to OrgProviderQuality@CalOptima.org

Organizational Provider/ Site Review Tool & Corrective Action Plan					Survey Date:	
Type of Organizational Provider					**Reviewer Information**	
	Total Number of on-site staff =				**Reviewer Name:**	
Name of Organization:	Physician(s)		NP(s)			
	RN(s)		PA(s)		**Reviewer's Organization Name:**	
Address, City, ST, ZIP:	LVN(s)		RD(s)			
	Clerical (s)		LCSW/SW(s)		**Reviewer Phone:**	
Phone:	Other:					
	Site Visit Purpose				**Reviewer Email:**	
Fax Number:		**Initial Assessment/ Re-Assessment (Mark X if applicable)**				
		Complaint Review (Mark X if applicable)				
Administrator Name:		**CAP Follow-up 1 (Date of this Follow-up)**			**Corrective Action Plan**	
		CAP Follow-up 2 (Date of this Follow-up)			**Scores below [enter % per your organizations policy] require a CAP.**	
Nursing Director Name:						
		Other:			**[Optional may define other CAP requirements here] Critical element deficiency requires CAP regardless of score.**	
Medical Director Name:						

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Assessment Summary				
		Points Earned	Actual Available Points*	Possible Available Points*
A.	Administrative Services	0	0	4
B.	Policies & Procedures	0	0	10
C.	Personnel	0	0	4
D.	Environment	0	0	9
E.	Environment - Emergency Plan	0	0	7
F.	Infection Control	0	0	11
G.	QAPI	0	0	5
H.	QAPI - Documents	0	0	5
I.	Medical Records	0	0	6

CAP INFORMATION	
Next Follow-up Date:	
Next Follow-up Date:	
CAP Closure Date:	
In-person visit	
Documentation Req'd	
Telephone follow-up	

Facility Score	
Total Points Earned:	0
Total Points Available:*	0
Total Score :	#DIV/0!

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Name of Organization:	Date of Survey:			Facility Audit Tool
A. Administrative Services	**YES**	**NO**	**N/A**	**COMMENTS**
1. Organization has local, state License/Certification as needed. Information is appropriately posted.				
2. There is an established organizational structure with defined functions and responsibilities. (This may be an organizational chart or other document)				
3. The OP clearly identified contracted services and temporary staff.				
4. There is access to interpreter services for patients with limited English proficiency and those with hearing impairments.				
B. Policies & Procedures	**YES**	**NO**	**N/A**	**COMMENTS**
1. Medical Record keeping				
2. Infection Control				
· Qualified Infection Control Professional				
· Vaccinations encouraged and monitored				
· Personal Protective Equipment				
· Hazardous waste				
3. Equipment Maintenance				
4. Emergency Procedures				
5. Patient Rights: The patients' rights are protected according to the regulations appropriate for the facility. This may include the right to give informed consent (in the appropriate language) ; the right to privacy and the privacy of personally identifiable healthcare information; and the right to report grievances , abuse or neglect.				
6. There is a policy & procedure regarding licensure & credentialing and privileging of staff.				
7. There is evidence that the policies & procedures have been reviewed, revised, and approved. periodically				

C. Personnel	**YES**	**NO**	**N/A**	**COMMENTS**
1. Physician(s) and other LIP(s) are credentialed and privileged according to policy and procedures.				
2. Rendering and Supervising Personnel have License, Training, and Education on file.				
3. There is evidence that agency/contracted staff are appropriately reviewed.				
4. There is documentation of staff education and training.				

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Name of Organization:	Date of Survey:			Facility Audit Tool
D. Environment	**YES**	**NO**	**N/A**	**COMMENTS**
1. There are accessible exits which are clearly marked and emergency evacuation routes are posted.				
2. There is evidence of sufficient fire protection equipment (smoke detectors, fire extinguishers, fire blankets, etc.) and a record of fire drills.				
3. Medical equipment is clean, in good working condition and inspected according to policy and procedures to assure safety.				
4. There is sufficient handicap parking, access and accommodations within the building.				
5. Bio hazard waste is handled appropriately and there is a contract for its regular disposal.				
6. The facility is clean and the waiting area is of sufficient size to accommodate patients comfortably and to assure privacy during registration.				
7. Life Safety Code waivers (if any) no not adversely affect the operation of the facility.				
8. OP with special requirements (such as Dialysis Centers and Ambulatory surgical centers) follow established guidelines.				
9. Medication refrigerator temperature trending logs are correct and complete per policy and procedure.				

E. Environment - Emergency Plan	**YES**	**NO**	**N/A**	**COMMENTS**
1. The OP has a health care emergency plan in which staff have received training.				
2. If part of the plan, a readily accessible Crash Cart is on site that contains at least the following:				
a. Defibrillator, or AED.				
b. Suction				
c. Airway Management Devices (airways, oxygen masks/cannulas, ambu bag)				
d. Medications (per Medical Emergencies Policy)				
3. Emergency phone numbers posted at nurse's station are current.				
4. Staff with Advance Life Support (ALS) and/or Basic Life Support (BLS) are identified and their certification is current				

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Name of Organization:	Date of Survey:			Facility Audit Tool
F. Infection Control Practices	**YES**	**NO**	**N/A**	**COMMENTS**
1. Does the OP have an infection control program based on established Policies and Procedures.				
2. Does the Infection Control program follow recognized guidelines.				
3. Does the OP have a licensed professional qualified to direct the program.				
4. Does the OP have a system to encourage vaccinations and prevent the spread of infections.				
5. Do staff members receive IC training.				
6. Do staff perform good hand hygiene.				
7. Do staff use good injection practices(injectable medication, saline, and other infusates)				
8. Environmental cleaning is appropriate and staff receive training				
9. Point of care devices used and cleaned appropriately.				
10. Proper use of Personal Protective Equipment observed (gloves, gowns, masks, etc.)				
11. Infection Control information is reviewed as part of Quality Assurance Performance Improvement.				

G. Quality Assurance Performance Improvement (QAPI)	**YES**	**NO**	**N/A**	**COMMENTS**
1. Is there a QAPI committee which meets regularly and keeps minutes				
2. The QAPI committee reviewed performance standards for medical records, infection control, environment, personnel and other areas of concern.				
3. The QAPI identified concerns, initiated corrective actions plans, monitored the results of the plans, and made appropriate changes based on an analysis of the data.				
4. The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches, complaints and grievances) and takes appropriate actions.				
5. The QAPI committee has reviewed surveys, inspections, and reports submitted by outside agencies. Corrective action plans are available.				

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Name of Orgaization:	Date of Survey:			Facility Audit Tool
H. QAPI Documentation Which Demonstrates Compliance	**YES**	**NO**	**N/A**	**COMMENTS**
1. Designated QA&PI coordinator.				
2. The QAPI committee reviewed performance standards for medical records, infection control, environment, personnel and other areas of concern.				
3. The QAPI identified concerns, initiated corrective action plans, monitored the results of the plans and made changes on based on an analysis of the data.				
4. The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches, complaints and grievances) and takes appropriate actions.				
5. The QAPI committee has reviewed surveys, inspections, and reports from outside agencies. They have copies of the corrective action plans.				

I. Medical Records/BH Review	YES	NO	N/A	COMMENTS
1. The Policies and Procedures must reflect current practices, assure privacy, and include Electronic Medical Records if used. All entries in the medical record follow established policy and procedure.				
2. Admission data is complete, informed consents, H&P and notes are signed and dated.				
3. All known Allergies are noted in the record.				
4. The medical records are uniquely identified to safeguard patient privacy.				
5. Advanced directives and surrogate healthcare decision makers are noted in the record.				
6 . Policy and procedures allow prompt retrieval and long term storage of medical records for the time required by regulation.				

Additional Information	YES	NO	N/A	COMMENTS

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Organizational Provider/ Site Review Tool

Corrective Action Plan (CAP) Follow-Up

Name of Organization:	Date of Survey	Reviewer Name:	
	DD/MM/YYY	(Reviewer Name here)	
Deficiency # and Description	**Date of Comment**	**Comments**	**CAP Closed**

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Policy:	GG.1651Δ
Title:	**Assessment and Re-Assessment of Organizational Providers**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	06/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

For 20200604 BOD Review Only

I. PURPOSE

This policy establishes the framework to assess Organizational Providers' (OPs') participation eligibility in the CalOptima provider network, prior to contracting and every three (3) years thereafter.

II. POLICY

A. CalOptima shall establish guidelines by which CalOptima shall evaluate and select OPs to participate in CalOptima, in accordance with Title 42, Code of Federal Regulations, Section 422.204 and other applicable laws, regulations, and guidance.

B. CalOptima may delegate the assessment and reassessment of OPs to a Health Network in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Health Network shall establish policies and procedures to assess and reassess OPs to participate in its CalOptima network that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO), or his or her physician Designee, shall have direct responsibility over and actively participate in the assessment and reassessment of an OP.

D. The CalOptima Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an OP's application information and CalOptima's findings for determining OP's participation in CalOptima's network.

E. CalOptima shall require that the OP be successfully assessed, including confirmation that the OP is in good standing with state and federal regulatory agencies, prior to contracting and every three (3) years thereafter

F. CalOptima shall require OPs to be reviewed and approved by an accrediting body or received an on-site quality assessment consistent with the provisions of this Policy if the provider is not accredited, as applicable.

G. CalOptima shall ensure that the OP is actively enrolled in Medi-Cal, as applicable.

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H. On a monthly basis, CalOptima shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List and Medi-Cal Suspended & Ineligible (S&I). CalOptima shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Actions.

I. If CalOptima declines to include an OP in the CalOptima network, CalOptima shall notify, in writing, such OP within sixty (60) calendar days of the reason for its decision. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Policies HH.1101: CalOptima Provider Compliant and MA.9006: Provider Complaint Process, as applicable.

J. CalOptima shall maintain the confidentiality of credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

K. The CalOptima Board of Directors shall review and approve this Policy periodically.

III. PROCEDURE

A. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section II.H. of this Policy.

2. The OP shall submit an application, signed and dated by an authorized official of the OP, along with the following supplemental documentation:

   a. Confirmation that the OP is in compliance with any other applicable state or federal requirements, and possess a business license (or business tax certificate), as applicable;

   b. Accreditation and/or Government Issued Certification, as applicable. Issuing bodies include, but are not limited to:

      i. The Joint Commission (TJC): A copy of the certificate of accreditation by the Joint Commission, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

      ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

      iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, prosthetics and orthotics supplies, and opioid treatment programs;

      iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

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v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing and audiology certification;

vii. Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS);

viii. Commission on accreditation of ambulance services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, Durable Medical Equipment prosthetics orthotic suppliers, pharmacies; and

xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging providers, and procedure-based modalities.

c. If an OP is not accredited, the OP may submit evidence of an on-site quality review by the state, CMS, or similar agency, or CalOptima must provide evidence of on-site quality review. The on-site quality review must include the criteria used for the assessment, and the process for ensuring that the providers credential their Practitioners. The State, CMS, or a similar agency, quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima shall conduct its own onsite quality review.

d. Certificate of current liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable:

i. General/Commercial Liability Insurance;

ii. Professional liability;

iii. Worker's Compensation Insurance.

e. A copy of any history of sanctions, preclusions, exclusions, suspensions or terminations from Medicare and/or Medi-Cal, as applicable.

f. Active enrollment in Medi-Cal, if applicable;

g. A copy of the organization's Quality Plan, if applicable;

h. Staff roster and copy of all staff certifications, or licensure, if applicable;

i. A valid Type 2 National Provider Identifier (NPI) number;

j. IRS Form SS-4, if applicable; and

k. A current W-9.

3. CalOptima shall conduct and communicate the results of a Facility Site Review (FSR) for Community Clinics and Free-Standing Urgent Care centers providing services to CalOptima

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Members pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

B. OP Re-assessment

1. CalOptima shall reassess an OP at least every three (3) years after initial assessment. At the time of re-assessment, CalOptima shall:

   a. Collect and verify, at a minimum, all of the information required for initial assessment, as set forth in Section III.A. of this Policy; and

   b. Incorporate the following data in the decision-making process:

      i. Quality review activities, including but not limited to, information from:

         a) DHCS, CMS, or another agency, as applicable;

         b) CalOptima quality review results, including, but not limited to, Grievances, Appeals, Potential Quality Issue (PQI) cases, and Compliance cases, as applicable;

         c) Review of Facility Site Review (FSR) or Physical Accessibility Review Survey (PARS) results, as applicable; and

         d) Review of Medical Records, as applicable.

      iii. Member experience, if applicable;

      iv. Liability claims history, if applicable; and

      v. Compliance with the terms of the Provider's contract.

2. CalOptima shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima.

C. Credentialing Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding CalOptima's provider network.

2. Completed OP files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

   a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification there have been no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment has occurred, and confirmation that the OP is in good standing with state and federal regulatory agencies.

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i. A clean file shall be considered approved and effective on the date that the CMO, or his or her physician Designee, review and approve an OP's assessment and re-assessment file, and deem the file clean.

ii. Approved, clean file lists shall be presented at the CPRC and reflected in the meeting minutes.

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the OP.

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the provider submits all the required information.

ii. CPRC minutes shall reflect thoughtful consideration of information presented in the file.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

3. The CPRC shall make recommendations based on the OP's ability to deliver services based on the information collected from the file review process.

a. The CalOptima Quality Improvement Department shall send the OP, or applicant, a decision letter, within sixty (60) calendar days of the Initial decision:

i. Acceptance;

ii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

4. Upon acceptance of the participation application, the CalOptima Quality Improvement Department shall generate a provider profile and forward the provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and provider data into CalOptima's core business system, which updates pertinent information into the online Provider Directory.

IV. ATTACHMENTS

A. Organizational Provider Application
B. Onsite Quality Review Tool

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with 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

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F. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy GG.1607Δ: Monitoring Adverse Actions
I. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
J. CalOptima Policy HH.1101: CalOptima Provider Compliant
K. CalOptima Policy MA.9006: Provider Complaint Process
N. Department of Health Care Services All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment
O. California Evidence Code, §1157
P. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 424, 431 and 455.450
Q. Title 45, Code of Federal Regulations, §455
R. Title 42, United States Code, §1320a-7(a)
S. Title XVIII and XIV of the Social Security Act
T. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651Δ	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1651Δ	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	A request by the Member or the Member's Authorized Representative for review of any decision to deny, modify, or discontinue a Covered Service.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a provider to provide quality and safe patient care services.
Credentialing Peer Review Committee	Peer review body who reviews provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Durable Medical Equipment (DME)	Durable medical equipment means equipment prescribed by a licensed practitioner to meet 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 an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Facility Site Review	An on-site inspection of primary care sites to evaluate the capacity or continuing capacity of a site to support the delivery of quality health care services using the DHCS Facility Site Review (FSR), Medical Record Review (MRR) or Physical Accessibility Review Survey (PARS) tools.
Grievance	An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that health network.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An enrollee-beneficiary of a CalOptima program.
Organizational Provider	Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, and portable x-ray suppliers.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers

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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	Any person or institution that furnishes Covered Services.
Re-Assessment	The process by which provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.

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Applicant Tax ID:_____

Organizational Provider (OP)
Quality Assessment Application
and Survey of Specialties and Services

The following application is for organizations which intend to contract with CalOptima. Upon approval, organization then becomes eligible contract should CalOptima be in need of the provider type or services organization provides. Please complete application as accurately and completely as possible. Inclomplete applications will not be accepted. In the event organization is assigned with either a moderate or high risk level, CalOptima may perform an on-site visit.

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Name of Organization:			
DBA (If Applicable):			
Billing NPI:		**Tax ID:**	
Business Type:	[ ] LLC	[ ] Corporation	[ ] LP

Line of Business Intended to Contract as:

[ ] CalMediConnect	[ ] Medi-Cal	[ ] OneCare
CalOptima Program(s)	[ ] Behavioral Health	[ ] PACE	[ ] MSSP / IHSS

Registrations and Enrollment

Type	ID	Effective Date	Type/Specialty
Medi-Cal Registration/Enrollment			
Medicare Registration/Enrollment			
Medicare (CMS) Certification			
DHCS/California Licensure			
California Children's Services			

Primary Specialty: _____ *select from one listed in 'Organization Specialty" section below*

Organization Type:

[ ] Agency	[ ] Laboratory	[ ] Respite Care
[ ] Ambulatory Care Facility	[ ] Practitioner/Physician Group	[ ] Supplier
[ ] Hospital	[ ] Nursing & Custodial Care Facility	[ ] Transportation Services
[ ] Hospital Unit	[ ] Residential Treatment Facility	[ ] Other

Count of Accreditations Held _____ **Count of Service Addresses** _____

Business/Administrative Information

Business Address

Street **Suite/Unit #** **City** **State** **Zip**

Phone **Fax**

Business License / Tax Certificate Issued By:

Billing Address

[ ] *Billing is performed by a third party. If so, indicate company name*_____

Street **Suite/Unit #** **City** **State** **Zip**

Phone **Fax**

Mailing Address

[ ] *Mailing address is the same as the business address*

Street **Suite/Unit #** **City** **State** **Zip**

Phone **Fax**

Organization's Authorized Official(s)

Authorized Official Name			
Title			
Email Address		**Contact Phone**	

If applicable to applicant organization, supply the below contact information. **Please note CalOptima uses email as the primary method for communication.** If a similar role is held by your organization, please enter the individuals information.

	Name	Email Address
Practitioner Credentialing Contact		
CEO *(Chief Executive Officer)*		
CAO *(Chief Administration Officer)*		
CMO *(Chief Medical Officer)*		
CFO *(Chief Financial Officer)*		
Director of Nursing		

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Applicant Tax ID:_____

Organization Accreditation or Government Issued Certification *(If more than one is held, complete page 3 for each held)*

Accrediting/Certifying Body	
Identification Number	

[ ] Check if on-site visit was performed

Last Survey Date	
Next Survey Date	

Check all which apply below, as it applies to the organization's accreditation or Certification. Data will be used to assist with Member Referrals and Authorizations

Administration

- [ ] Case Management (CM)
- [ ] Credentialing/Staffing (CR)
- [ ] Patient Safety/Plan (PS)
- [ ] Quality Improvement/Plan (QI)
- [ ] Utilization Management (UM)

Programs/Services

- [ ] Ambulatory Care
- [ ] Ambulatory Surgery
- [ ] Anesthesia
- [ ] Aquatic Therapy
- [ ] Behavioral Health
- [ ] Behavioral Health (Home)
- [ ] Canes and Crutches
- [ ] Chronic Kidney Disease
- [ ] Chronic Obstructive Pulmonary Disease
- [ ] Community Integration
- [ ] Comprehensive Cardiac Center
- [ ] Convenient Care
- [ ] CT Scanner
- [ ] Custom Othoses Fabricated
- [ ] Dementia Care
- [ ] Dentistry
- [ ] Diabetes Self Management
- [ ] Diagnostic Imaging
- [ ] Dialysis
- [ ] Donor Center / Testing
- [ ] Durable Medical Equipment
- [ ] EEG/EKG/FMG Lab
- [ ] Emergency Medicine/Department
- [ ] Enteral Nutrients
- [ ] Gastroenterology
- [ ] Gynecology
- [ ] Heart Failure
- [ ] Heart Failure
- [ ] Hip and Knee Replacement

Programs/Services, cont.

- [ ] Home Care
- [ ] Home Health (Aides)
- [ ] Home Health (Non-Hospice)
- [ ] Hospital
- [ ] Hospital (Critical Access)
- [ ] Hospital (Pediatric)
- [ ] Hospital (Psychiatric)
- [ ] Hospital Beds - Electric
- [ ] Hospital Beds - Manual
- [ ] Immunohematology
- [ ] Inpatient Diabetes
- [ ] Inpatient Unit
- [ ] Laboratory (General)
- [ ] Lung Volume Reduction Surgery
- [ ] Magnetic Resonance Imaging (MRI)
- [ ] Medical/Surgical Unit
- [ ] Molecular Testing
- [ ] Nebulizers Equipment
- [ ] Nursing Care
- [ ] Obstetrics
- [ ] Occupational Therapy
- [ ] Office Based Surgery
- [ ] Orthopedic Surgery
- [ ] Out of Hospital Transfusion Administra
- [ ] Out Patient Clinic
- [ ] Trigger Point Injections
- [ ] Palliative Care
- [ ] Palliative Care (Community Based)
- [ ] Patient Lists and Accessories
- [ ] Pediatric Medicine
- [ ] Perform Invasive Procedure
- [ ] Perinatal Care
- [ ] Perioperative Service
- [ ] Personal Care/Support (Non-Hospice)
- [ ] Pharmacy/Dispensary (General)

Programs/Services, cont.

- [ ] Physical Therapy
- [ ] Plastic Surgery
- [ ] Post-Acute Care
- [ ] Primary Care Medical
- [ ] Primary Stroke Center
- [ ] Rehabilitation Services
- [ ] Respiratory Equipment
- [ ] Skilled Nursing (Care)
- [ ] Skilled Nursing (Services)
- [ ] Social Services
- [ ] Social Services (Medical)
- [ ] Speech Language Pathology
- [ ] Stroke (Advance)
- [ ] Stroke (Comprehensive)
- [ ] Supplies
- [ ] Support Surfaces for Beds
- [ ] Thrombectomy-Capable Stroke Center
- [ ] Transfusion Service
- [ ] Ultrasound
- [ ] Ventricular Assist Device
- [ ] Walkers, Canes and Crushes
- [ ] Wheelchairs - Manual (Non-Custom)
- [ ] X-ray
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____

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Organizational Specialties

( ) Single-specialty ( ) Multi-specialty

Please identify all specialties below which apply to applicant organization in which intentions are to either contract or submit claims for. Additionally, for each identified specialty, also identify if either an accreditation, certification and/or license is held by the applicant for the specialty.

Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
	Agencies			
[ ]	Case Management	251B00000X	[ ]	[ ]
[ ]	Day Training, Developmentally Disabled Services	251C00000X	[ ]	[ ]
[ ]	Home Health	251E00000X	[ ]	[ ]
[ ]	Home Health (subunit)	251E00000X	[ ]	[ ]
[ ]	Home Infusion	251F00000X	[ ]	[ ]
[ ]	Hospice Care, Community Based	251G00000X	[ ]	[ ]
[ ]	Nursing Care	251J00000X	[ ]	[ ]
[ ]	Public Health or Welfare	251K00000X	[ ]	[ ]
[ ]	Community/Behavioral Health	251S00000X	[ ]	[ ]
[ ]	Program of All-Inclusive Care for the Elderly (PACE) Provider Organization	251T00000X	[ ]	[ ]
[ ]	Voluntary or Charitable	251V00000X	[ ]	[ ]
[ ]	Early Intervention Provider Agency	252Y00000X	[ ]	[ ]
[ ]	In Home Supportive Care	253Z00000X	[ ]	[ ]
	Ambulatory Health Care Facilities [Clinic/Center]			
[ ]	Ambulatory Family Planning Facility	261QA0005X	[ ]	[ ]
[ ]	Adult Day Care	261QA0600X	[ ]	[ ]
[ ]	Ambulatory Surgical	261QA1903X	[ ]	[ ]
[ ]	Birthing	261QB0400X	[ ]	[ ]
[ ]	Critical Access Hospital	261QC0050X	[ ]	[ ]
[ ]	Community Health	261QC1500X	[ ]	[ ]
[ ]	Corporate Health	261QC1800X	[ ]	[ ]
[ ]	Dental	261QD0000X	[ ]	[ ]
[ ]	Developmental Disabilities	261QD1600X	[ ]	[ ]
[ ]	Emergency Care	261QE0002X	[ ]	[ ]
[ ]	End-Stage Renal Disease (ESRD) Treatment	261QE0700X	[ ]	[ ]
[ ]	Endoscopy	261QE0800X	[ ]	[ ]
[ ]	Family Planning, Non-Surgical	261QF0050X	[ ]	[ ]
[ ]	Federally Qualified Health Center (FQHC)	261QF0400X	[ ]	[ ]
[ ]	Genetics	261QG0250X	[ ]	[ ]
[ ]	Health Service	261QH0100X	[ ]	[ ]
[ ]	Hearing and Speech	261QH0700X	[ ]	[ ]
[ ]	Infusion Therapy	261QI0500X	[ ]	[ ]
[ ]	Mental Health (Including Community Mental Health Center)	261QM0801X	[ ]	[ ]
[ ]	Adult Mental Health	261QM0850X	[ ]	[ ]
[ ]	Adolescent and Children Mental Health	261QM0855X	[ ]	[ ]
[ ]	Migrant Health	261QM1000X	[ ]	[ ]
[ ]	Magnetic Resonance Imaging (MRI)	261QM1200X	[ ]	[ ]

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Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
Ambulatory Health Care Facilities [Clinic/Center] (cont.)				
[ ]	Medical Specialty	261QM2500X	[ ]	[ ]
[ ]	Methadone	261QM2800X	[ ]	[ ]
[ ]	Podiatric	261QP1100X	[ ]	[ ]
[ ]	Physical Therapy	261QP2000X	[ ]	[ ]
[ ]	Primary Care	261QP2300X	[ ]	[ ]
[ ]	Pain	261QP3300X	[ ]	[ ]
[ ]	Radiology	261QR0200X	[ ]	[ ]
[ ]	Radiology, Mammography	261QR0206X	[ ]	[ ]
[ ]	Radiology, Mobile Mammography	261QR0207X	[ ]	[ ]
[ ]	Radiology, Mobile	261QR0208X	[ ]	[ ]
[ ]	Outpatient Rehabilitation (mixed specialty - OT,PT,SLP)	261QR0400X	[ ]	[ ]
[ ]	Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	261QR0401X	[ ]	[ ]
[ ]	Rehabilitation, Cardiac Facilities	261QR0404X	[ ]	[ ]
[ ]	Rehabilitation, Substance Use Disorder	261QR0405X	[ ]	[ ]
[ ]	Research	261QR1100X	[ ]	[ ]
[ ]	Rural Health	261QR1300X	[ ]	[ ]
[ ]	Oral and Maxillofacial Surgery	261QS0112X	[ ]	[ ]
[ ]	Ophthalmologic Surgery	261QS0132X	[ ]	[ ]
[ ]	Sleep Disorder Diagnostic	261QS1200X	[ ]	[ ]
[ ]	Urgent Care	261QU0200X	[ ]	[ ]
[ ]	Occupational Medicine	261QX0100X	[ ]	[ ]
[ ]	Oncology	261QX0200X	[ ]	[ ]
[ ]	Oncology, Radiation	261QX0203X	[ ]	[ ]
[ ]	Optometry	152W00000X	[ ]	[ ]
Hospitals				
[ ]	Chronic Disease Hospital	281P00000X	[ ]	[ ]
[ ]	Chronic Disease Hospital [Pediatric]	281PC2000X	[ ]	[ ]
[ ]	Long Term Care Hospital	282E00000X	[ ]	[ ]
[ ]	General Acute Care Hospital	282N00000X	[ ]	[ ]
[ ]	General Acute Care Hospital [Critical Care]	282NC0060X	[ ]	[ ]
[ ]	General Acute Care Hospital [Pediatric]	282NC2000X	[ ]	[ ]
[ ]	General Acute Care Hospital [Rual]	282NR1301X	[ ]	[ ]
[ ]	General Acute Care Hospital [Women's]	282NW0100X	[ ]	[ ]
[ ]	Psychiatric Hospital	283Q00000X	[ ]	[ ]
[ ]	Rehabilitation Hospital	283X00000X	[ ]	[ ]
[ ]	Rehabilitation Hospital [Pediatric]	283XC2000X	[ ]	[ ]
[ ]	Religious Non-Medical Health Care Institution	282J00000X	[ ]	[ ]
[ ]	Special Hospital	284300000X	[ ]	[ ]
[ ]	Military Hospital	286500000X	[ ]	[ ]
[ ]	Military Hospital [General Acute Care Hospital]	2865M2000X	[ ]	[ ]

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Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
	Hospital Units			
[ ]	Epilepsy Unit	273100000X	[ ]	[ ]
[ ]	Psychiatric Unit	273R00000X	[ ]	[ ]
[ ]	Rehabilitation Unit	273Y00000X	[ ]	[ ]
[ ]	Medicare Defined Swing Bed Unit	275N00000X	[ ]	[ ]
[ ]	Rehabilitation, Substance Use Disorder Unit	276400000X	[ ]	[ ]
	Laboratories			
[ ]	Military Clinical Medical Laboratory	291900000X	[ ]	[ ]
[ ]	Clinical Medical Laboratory	291U00000X	[ ]	[ ]
[ ]	Dental Laboratory	292200000X	[ ]	[ ]
[ ]	Physiological Laboratory	293D00000X	[ ]	[ ]
	Organizations			
[ ]	Exclusive Provider Organization	302F00000X	[ ]	[ ]
[ ]	Health Maintenance Organization	302R00000X	[ ]	[ ]
[ ]	Preferred Provider Organization	305R00000X	[ ]	[ ]
[ ]	Point of Service	305S00000X	[ ]	[ ]
	Nursing & Custodial Care Facilities			
[ ]	Assisted Living Facility	310400000X	[ ]	[ ]
[ ]	Intermediate Care Facility, Mental Illness	310500000X	[ ]	[ ]
[ ]	Alzheimer Center (Dementia Center)	311500000X	[ ]	[ ]
[ ]	Custodial Care Facility	311Z00000X	[ ]	[ ]
[ ]	Custodial Care Facility [Adult Care Home]	311ZA0620X	[ ]	[ ]
[ ]	Nursing Facility/Intermediate Care Facility	313M00000X	[ ]	[ ]
[ ]	Skilled Nursing Facility	314000000X	[ ]	[ ]
[ ]	Skilled Nursing Facility [Pediatric]	3140N1450X	[ ]	[ ]
[ ]	Hospice, Inpatient	315D00000X	[ ]	[ ]
[ ]	Intermediate Care Facility, Mentally Retarded	315P00000X	[ ]	[ ]
	Residential Treatment Facilities			
[ ]	Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities	320600000X	[ ]	[ ]
[ ]	Residential Treatment Facility, Physical Disabilities	320700000X	[ ]	[ ]
[ ]	Community Based Residential Treatment Facility, Mental Illness	320800000X	[ ]	[ ]
[ ]	Community Based Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities	320900000X	[ ]	[ ]
[ ]	Residential Treatment Facility, Emotionally Disturbed Children	322D00000X	[ ]	[ ]
[ ]	Psychiatric Residential Treatment Facility	323P00000X	[ ]	[ ]
[ ]	Substance Abuse Rehabilitation Facility	324500000X	[ ]	[ ]
[ ]	Substance Abuse Rehabilitation Facility [Pediatric]	3245S0500X	[ ]	[ ]
	Respite Care Facility			
[ ]	Respite Care	385H00000X	[ ]	[ ]

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Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
	Suppliers			
[ ]	Blood Bank	331L00000X	[ ]	[ ]
[ ]	Military/U.S. Coast Guard Pharmacy	332000000X	[ ]	[ ]
[ ]	Department of Veterans Affairs (VA) Pharmacy	332100000X	[ ]	[ ]
[ ]	Non-Pharmacy Dispensing Site	332900000X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies	332B00000X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Customized Equipment]	332BC3200X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Dialysis Equipment]	332BD1200X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Nursing Facility Supplies]	332BN1400X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Perenteral & Enteral Nutrition]	332BP3500X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies [Oxygen Equipment & Supplies]	332BX2000X	[ ]	[ ]
[ ]	Eyewear Supplier	332H00000X	[ ]	[ ]
[ ]	Hearing Aid Equipment	332S00000X	[ ]	[ ]
[ ]	Home Delivered Meals	332U00000X	[ ]	[ ]
[ ]	Emergency Response System Companies	333300000X	[ ]	[ ]
[ ]	Pharmacy	333600000X	[ ]	[ ]
[ ]	Pharmacy[Clinic Pharmacy]	3336C0002X	[ ]	[ ]
[ ]	Pharmacy[Community Retail]	3336C0003X	[ ]	[ ]
[ ]	Pharmacy[Compounding Pharmacy]	3336C0004X	[ ]	[ ]
[ ]	Pharmacy[Home Infusion Therapy Pharmacy]	3336H0001X	[ ]	[ ]
[ ]	Pharmacy[Institutional Pharmacy]	3336I0012X	[ ]	[ ]
[ ]	Pharmacy[Long Term Care Pharmacy]	3336L0003X	[ ]	[ ]
[ ]	Pharmacy[Mail Order Pharmacy]	3336M0002X	[ ]	[ ]
[ ]	Pharmacy[Managed Care Organization Pharmacy]	3336M0003X	[ ]	[ ]
[ ]	Pharmacy[Nuclear Pharmacy]	3336N0007X	[ ]	[ ]
[ ]	Pharmacy[Specialty Pharmacy]	3336S0011X	[ ]	[ ]
[ ]	Prosthetic/Orthotic Supplier	335E00000X	[ ]	[ ]
[ ]	Medical Foods Supplier	335G00000X	[ ]	[ ]
[ ]	Organ Procurement Organization	335U00000X	[ ]	[ ]
[ ]	Portable X-ray and/or Other Portable Diagnostic Imaging Supplier	335V00000X	[ ]	[ ]
	Transportation Services			
[ ]	Ambulance [Air Transport]	3416A0800X	[ ]	[ ]
[ ]	Ambulance [Land Transport]	3416L0300X	[ ]	[ ]
[ ]	Ambulance [Water Transport]	3416S0300X	[ ]	[ ]
[ ]	Military/U.S. Coast Guard Transport	341800000X	[ ]	[ ]
[ ]	Secured Medical Transport (VAN)	343800000X	[ ]	[ ]
[ ]	Non-emergency Medical Transport (VAN)	343900000X	[ ]	[ ]
[ ]	Transportation Broker	347E00000X	[ ]	[ ]

For 20200604 BOD Review Only

If specialty is not found in this section please provide the following:

	Specialty	Taxonomy Code *(if known)*
Primary Specialty		
Specialty 2		
Specialty 3		
Specialty 4		
Specialty 5		
Specialty 6		

Section intentionally left blank

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Applicant Tax ID:_____

Service Address(es)	Location 1 of _____

[ ] Check if location is included in organization's accreditation

Address Type(s) [ ] After hours [ ] Service Address [ ] Unit

If applicable, alternate location name

Location NPI

Street **Suite/Unit#** **City** **State** **Zip**

Member Access Phone

Member Fax

Admit Address for After Hours? ☐ YES ☐ NO

After Hours Phone Number

Website URL:

Administrative Contact for Location

Name Phone Email

Hours of Operation: [ ] Check if open 24/7

☐ Including holidays ☐ Excluding holidays

		SUN	MON	TUE	WED	THU	FRI	SAT
AM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:
PM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:

Ages Served

[ ] Peri-Natal [ ] Child [ ] Adult

[ ] Infant [ ] Adolescent [ ] Geriatric

Languages Spoken

Enter all languages spoken by Member facing staff

Special Services at Location

☐ Location is Enrolled in Medi-Cal ☐ Telehealth Distant Site

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Applicant Tax ID:_____

Service Address(es)	**Location 2 of _____**

[ ] Check if location is included in organization's accreditation

Address Type(s) **[ ] After hours** **[ ] Service Address** **[ ] Unit**

If applicable, alternate location name	
Location/Unit NPI	

Street **Suite/Unit#** **City** **State** **Zip**

Member Access Phone

Member Fax

Admit Address for After Hours? ☐ YES ☐ NO

After Hours Phone Number

Website URL:

Administrative Contact for Location

Name Phone Email

Hours of Operation: **[ ] Check if open 24/7**

☐ Including holidays ☐ Excluding holidays

		SUN	MON	TUE	WED	THU	FRI	SAT
AM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:
PM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:

Ages Served			
	[ ] Peri-Natal	**[ ] Child**	**[ ] Adult**
	[ ] Infant	**[ ] Adolescent**	**[ ] Geriatric**

Languages Spoken

Enter all languages spoken by member facing staff

Special Services at Location

☐ Location is Enrolled in Medi-Cal ☐ Telehealth Distant Site

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Applicant Tax ID:_____

Service Address(es) | **Location 3 of _____**

[ ] Check if location is included in organization's accreditation

Address Type(s) [ ] After hours [ ] Service Address [ ] Unit

If applicable, alternate location name

Location NPI

Street **Suite/Unit#** **City** **State** **Zip**

Member Access Phone

Member Fax

Admit Address for After Hours? ☐ YES ☐ NO

After Hours Phone Number

Website URL:

Administrative Contact for Location

Name **Phone** **Email**

Hours of Operation [ ] Check if open 24/7

☐ Including holidays ☐ Excluding holidays

		SUN	MON	TUE	WED	THU	FRI	SAT
AM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:
PM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:

Ages Served

[ ] Peri-Natal [ ] Child [ ] Adult

[ ] Infant [ ] Adolescent [ ] Geriatric

Languages Spoken

Enter all languages spoken by member facing staff

Special Services at Location

☐ Location is Enrolled in Medi-Cal ☐ Telehealth Distant Site

For 20200604 BOD Review Only

Attestation

I attest that all of the information submitted by me in this document is true, correct, and complete to the best of my knowledge and belief. I understand that any significant misstatements in, or omissions from, this application may constitute cause for denial of participation or cause for summary dismissal from CalOptima or be subject to applicable State or Federal penalties for perjury. I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

You and your agents must meet CalOptima's Eligibility Status requirements. This means that you and your agents must be eligible to participate in Federal and/or State healthcare programs, including the Medi-Cal Program (not currently suspended, excluded or otherwise ineligible and not excluded at any time based on a mandatory exclusion in 42 U.S.C. 1396a-7(a), hold appropriate government issued licensures, not held liable in any criminal or civil proceedings for fraud waste or abuse and not convicted of a criminal offense related to healthcare in the prior seven (7) years).

Persons or entities that do not meet the Eligibility Status requirements are not eligible to receive reimbursement from CalOptima. As referred to in this application which also serves as CalOptima's registration form, "your agents" means all of your employees, subcontractors, and/or agents furnishing items or services to CalOptima and its members.

You and your agents must comply with any executed contracts with CalOptima, CalOptima's Compliance Program, all CalOptima Policies and Procedures applicable to items and/or services you furnish to CalOptima and its members.

Name of Authorized Official

Title of Authorized Official

Signature of Authorized Official

Date

Email Address

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Submit completed application and supplemental documents to OrgProviderQuality@CalOptima.org

Organizational Provider/ Site Review Tool & Corrective Action Plan					Survey Date:	
Type of Organizational Provider					**Reviewer Information**	
	Total Number of on-site staff =				**Reviewer Name:**	
Name of Organization:	Physician(s)		NP(s)			
	RN(s)		PA(s)		**Reviewer's Organization Name:**	
Address, City, ST, ZIP:	LVN(s)		RD(s)			
	Clerical (s)		LCSW/SW(s)		**Reviewer Phone:**	
Phone:	Other:					
	Site Visit Purpose				**Reviewer Email:**	
Fax Number:		**Initial Assessment/ Re-Assessment (Mark X if applicable)**				
		Complaint Review (Mark X if applicable)				
Administrator Name:		**CAP Follow-up 1 (Date of this Follow-up)**			**Corrective Action Plan**	
		CAP Follow-up 2 (Date of this Follow-up)			**Scores below [enter % per your organizations policy] require a CAP.**	
Nursing Director Name:						
		Other:			**[Optional may define other CAP requirements here] Critical element deficiency requires CAP regardless of score.**	
Medical Director Name:						

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Assessment Summary				
		Points Earned	Actual Available Points*	Possible Available Points*
A.	Administrative Services	0	0	4
B.	Policies & Procedures	0	0	10
C.	Personnel	0	0	4
D.	Environment	0	0	9
E.	Environment - Emergency Plan	0	0	7
F.	Infection Control	0	0	11
G.	QAPI	0	0	5
H.	QAPI - Documents	0	0	5
I.	Medical Records	0	0	6

CAP INFORMATION	
Next Follow-up Date:	
Next Follow-up Date:	
CAP Closure Date:	
In-person visit	
Documentation Req'd	
Telephone follow-up	

Facility Score	
Total Points Earned:	0
Total Points Available:*	0
Total Score :	#DIV/0!

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Name of Organization:	Date of Survey:			Facility Audit Tool
A. Administrative Services	**YES**	**NO**	**N/A**	**COMMENTS**
1. Organization has local, state License/Certification as needed. Information is appropriately posted.				
2. There is an established organizational structure with defined functions and responsibilities. (This may be an organizational chart or other document)				
3. The OP clearly identified contracted services and temporary staff.				
4. There is access to interpreter services for patients with limited English proficiency and those with hearing impairments.				
B. Policies & Procedures	**YES**	**NO**	**N/A**	**COMMENTS**
1. Medical Record keeping				
2. Infection Control				
· Qualified Infection Control Professional				
· Vaccinations encouraged and monitored				
· Personal Protective Equipment				
· Hazardous waste				
3. Equipment Maintenance				
4. Emergency Procedures				
5. Patient Rights: The patients' rights are protected according to the regulations appropriate for the facility. This may include the right to give informed consent (in the appropriate language) ; the right to privacy and the privacy of personally identifiable healthcare information; and the right to report grievances , abuse or neglect.				
6. There is a policy & procedure regarding licensure & credentialing and privileging of staff.				
7. There is evidence that the policies & procedures have been reviewed, revised, and approved. periodically				

C. Personnel	**YES**	**NO**	**N/A**	**COMMENTS**
1. Physician(s) and other LIP(s) are credentialed and privileged according to policy and procedures.				
2. Rendering and Supervising Personnel have License, Training, and Education on file.				
3. There is evidence that agency/contracted staff are appropriately reviewed.				
4. There is documentation of staff education and training.				

For 20200604 BOD Review Only

Name of Organization:	Date of Survey:			Facility Audit Tool
D. Environment	**YES**	**NO**	**N/A**	**COMMENTS**
1. There are accessible exits which are clearly marked and emergency evacuation routes are posted.				
2. There is evidence of sufficient fire protection equipment (smoke detectors, fire extinguishers, fire blankets, etc.) and a record of fire drills.				
3. Medical equipment is clean, in good working condition and inspected according to policy and procedures to assure safety.				
4. There is sufficient handicap parking, access and accommodations within the building.				
5. Bio hazard waste is handled appropriately and there is a contract for its regular disposal.				
6. The facility is clean and the waiting area is of sufficient size to accommodate patients comfortably and to assure privacy during registration.				
7. Life Safety Code waivers (if any) no not adversely affect the operation of the facility.				
8. OP with special requirements (such as Dialysis Centers and Ambulatory surgical centers) follow established guidelines.				
9. Medication refrigerator temperature trending logs are correct and complete per policy and procedure.				

E. Environment - Emergency Plan	**YES**	**NO**	**N/A**	**COMMENTS**
1. The OP has a health care emergency plan in which staff have received training.				
2. If part of the plan, a readily accessible Crash Cart is on site that contains at least the following:				
a. Defibrillator, or AED.				
b. Suction				
c. Airway Management Devices (airways, oxygen masks/cannulas, ambu bag)				
d. Medications (per Medical Emergencies Policy)				
3. Emergency phone numbers posted at nurse's station are current.				
4. Staff with Advance Life Support (ALS) and/or Basic Life Support (BLS) are identified and their certification is current				

For 20200604 BOD Review Only

Name of Organization:	Date of Survey:			Facility Audit Tool
F. Infection Control Practices	**YES**	**NO**	**N/A**	**COMMENTS**
1. Does the OP have an infection control program based on established Policies and Procedures.				
2. Does the Infection Control program follow recognized guidelines.				
3. Does the OP have a licensed professional qualified to direct the program.				
4. Does the OP have a system to encourage vaccinations and prevent the spread of infections.				
5. Do staff members receive IC training.				
6. Do staff perform good hand hygiene.				
7. Do staff use good injection practices(injectable medication, saline, and other infusates)				
8. Environmental cleaning is appropriate and staff receive training				
9. Point of care devices used and cleaned appropriately.				
10. Proper use of Personal Protective Equipment observed (gloves, gowns, masks, etc.)				
11. Infection Control information is reviewed as part of Quality Assurance Performance Improvement.				

G. Quality Assurance Performance Improvement (QAPI)	**YES**	**NO**	**N/A**	**COMMENTS**
1. Is there a QAPI committee which meets regularly and keeps minutes				
2. The QAPI committee reviewed performance standards for medical records, infection control, environment, personnel and other areas of concern.				
3. The QAPI identified concerns, initiated corrective actions plans, monitored the results of the plans, and made appropriate changes based on an analysis of the data.				
4. The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches, complaints and grievances) and takes appropriate actions.				
5. The QAPI committee has reviewed surveys, inspections, and reports submitted by outside agencies. Corrective action plans are available.				

For 20200604 BOD Review Only

Name of Orgaization:	Date of Survey:			Facility Audit Tool
H. QAPI Documentation Which Demonstrates Compliance	**YES**	**NO**	**N/A**	**COMMENTS**
1. Designated QA&PI coordinator.				
2. The QAPI committee reviewed performance standards for medical records, infection control, environment, personnel and other areas of concern.				
3. The QAPI identified concerns, initiated corrective action plans, monitored the results of the plans and made changes on based on an analysis of the data.				
4. The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches, complaints and grievances) and takes appropriate actions.				
5. The QAPI committee has reviewed surveys, inspections, and reports from outside agencies. They have copies of the corrective action plans.				

I. Medical Records/BH Review	YES	NO	N/A	COMMENTS
1. The Policies and Procedures must reflect current practices, assure privacy, and include Electronic Medical Records if used. All entries in the medical record follow established policy and procedure.				
2. Admission data is complete, informed consents, H&P and notes are signed and dated.				
3. All known Allergies are noted in the record.				
4. The medical records are uniquely identified to safeguard patient privacy.				
5. Advanced directives and surrogate healthcare decision makers are noted in the record.				
6 . Policy and procedures allow prompt retrieval and long term storage of medical records for the time required by regulation.				

Additional Information	YES	NO	N/A	COMMENTS

For 20200604 BOD Review Only

Organizational Provider/ Site Review Tool

Corrective Action Plan (CAP) Follow-Up

Name of Organization:	Date of Survey	Reviewer Name:	
	DD/MM/YYY	(Reviewer Name here)	
Deficiency # and Description	**Date of Comment**	**Comments**	**CAP Closed**

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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
36. Consider Authorizing the Chief Executive Officer (CEO) to Approve New and Revised Credentialing Policies, and to Retire Those No Longer Needed

Contact
Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Actions
Authorize the CEO to:
1. Approve new policies: GG.1650: Credentialing & Re-Credentialing of Practitioners and GG.1651: Credentialing and Re-Credentialing of Health Delivery Organizations (HDOs) (formerly GG.1609: Credentialing and Re-Credentialing and GG.1606: Credentialing & Re-Credentialing of Mid-Levels, with proposed changes);
2. Approve proposed revisions to: GG.1616: Fair Hearing; GG.1607: Monitoring of Adverse Activity; GG.1633: Board Certification; and
3. Retire: GG.1609: Credentialing & Re-Credentialing and GG.1606: Credentialing & Re-Credentialing of Mid-Levels.

Background
Over the last 16 months, CalOptima has been reviewing its procedures relating to initial and re-credentialing of practitioners and HDOs for effectiveness and efficiencies. This included a close evaluation of current processes and workflows within the Quality Improvement department as well as intersections with other areas including provider contracting, provider relations, network management, GARS, and audit & oversight. The attached policies and procedures have been updated with these revisions. The proposed policy changes were presented and approved by the Credentialing and Peer Review Committee on April 20, 2017.

Discussion
Certain technical language and substantive issues required modification or clarification for all of the following policies.

- GG. 1650: Credentialing & Re-Credentialing of Practitioners (formerly GG:1609 and GG: 1606):
  - Removed HDO references and created a new policy for Credentialing & Re-credentialing of HDOs (GG.1651);
  - Aligned requirements to new Department of Health Care Services (DHCS) All Plan Letter (APL) for:
    - Provider types (Physicians vs. Non-Physician Medical Practitioners)
    - Categorizing Practitioners by risk-level;
  - Merged Credentialing of Mid-levels into this policy, retiring GG.1606; strengthened language regarding supervising physician must be credentialed with CalOptima;
  - Clarified types of practitioners that are credentialed and not credentialed;

  - Added language to the Policy Section regarding final decisions being rendered within 180 days from date of licensure verification;
  - Added reference to GG.1643: Minimum Physician Standards;
  - Added language regarding work history verification (including all post-graduate activity in the last five years).

- GG. 1651: Credentialing and Re-Credentialing of Health Delivery Organizations:
  - Developed a credentialing policy specific to Health Delivery Organizations, which includes but is not limited to, hospitals, home health agencies, skilled nursing facilities, and free standing surgical centers;
  - Aligned requirements to meet new DHCS APL for:
    - Provider types (non-practitioner);
    - Categorizing of providers by risk-level;
    - Additional requirements for moderate and high risk providers;
  - Added HDO credentialing requirements:
    - Requires confirmation that a provider is in good standing;
    - Requires documentation of review and approval by an accredited body;
    - Requires on-site quality assessment if HDO is not accredited.

- GG. 1616: Fair Hearing;
  - Added language to describe the process CalOptima uses to provide a fair procedure to Practitioners when adverse actions are proposed or taken by CalOptima;
  - Updated language to differentiate CalOptima-initiated actions vs. practitioner-initiated actions vs. other disciplinary actions;
  - Clearly delineated actions as a result of medical disciplinary versus administrative cause or reason, and the handling of fair hearing rights specific to medical disciplinary cause or reason.

- GG. 1607: Monitoring of Adverse Activity:
  - Added a description of the monthly monitoring of adverse activities for practitioners, HDOs and other contracted and non-contracted providers;
  - Specifies the various entities that are monitored, including but not limited to OIG, SAM, NPDB, Medi-care Opt-Out, Medi-Cal Provider Suspended and Ineligible list, Medical Board of California;
  - Updated reporting requirements to DHCS and Health Networks when adverse activities are identified.

- GG. 1633: Board Certification:
  - Updated language that describes the requirements for board certification of contracted physicians;
  - Added language to address board certification requirements for certain specialties where shorter or longer time periods may apply, such as podiatric physicians;
  - Added language to clarify exemption for certain contracted physicians who meet specific requirements;

- Added language to align policy with Minimum Physician Standards policy GG.1643 effective July 1, 2016.

Staff also recommends retiring two policies, GG.1609: Credentialing & Re-Credentialing and GG.1606: Credentialing & Re-Credentialing of Mid-Levels, as the provisions included in these policies were incorporated into the new Policy GG.1650: Credentialing and Re-credentialing of Practitioners and Policy GG.1651: Credentialing and Re-credentialing of HDOs.

Fiscal Impact
There is no anticipated fiscal impact for the recommended actions to revise and retire specified internal credentialing policies.

Rationale for Recommendation
The proposed changes better align with revised workflows, differentiate requirements for practitioners and HDOs, and clarify processes for adverse activity monitoring, the fair hearing process, and board certification requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation, Credentialing Policy Updates
2. Proposed Revised Policy GG.1650: Credentialing and Re-Credentialing of Practitioners;
3. Proposed Revised Policy GG. 1651: Credentialing and Re-Credentialing of Health Delivery Organizations;
4. Proposed Revised Policy GG.1616: Fair Hearing;
5. Proposed Revised Policy GG.1607: Monitoring of Adverse Activity;
6. Proposed Revised Policy GG. 1633: Board Certification;
7. Proposed Retirement of Policy GG.1609: Credentialing and Re-Credentialing (Retire); and
8. Proposed Retirement of GG.1606: Credentialing and Re-Credentialing of Mid-Levels (Retire).

/s/ Michael Schrader — *5/25/2017*
Authorized Signature — **Date**

Credentialing Policy Updates

Board of Directors Meeting

June 1, 2017

Richard Bock, Deputy Chief Medical Officer,

Caryn Ireland, Executive Director, Quality and Analytics

NEW BUSINESS

- Updates on Credentialing Policies:
  - GG.1650 Credentialing & Re-Credentialing of Practitioners (Formerly GG.1609)
  - GG.1651 Credentialing & Re-Credentialing of Health Delivery Organizations (New)
  - GG.1633 Board Certification
  - GG.1616 Fair Hearing
  - GG.1607 Monitoring of Adverse Activity
  - GG.1609 Credentialing & Re-Credentialing (Retire)
  - GG.1606 Credentialing & Re-Credentialing of Mid-Levels (Retire)

Summary of Changes

Policy No./ Name	Summary of Changes	Reason for Change
GG.1650 Credentialing and Re-Credentialing of Practitioners (New number, formerly GG.1609)	• Removed HDO references and created new Credentialing/Re-Credentialing for HDO policy GG.1651 ▪ Aligned to new DHCS APL for: ▪ Provider types (Physicians vs. Non-Physician Medical Practitioners) ▪ Categorizing Practitioners by Risk-level ▪ Merged Credentialing of Mid-levels into the policy, retiring GG.1606. Supervising physician must be credentialed with CalOptima.	• Requirements for HDO's are different • Alignment to DHCS APL 16-012 for Credentialing • Credentialing of Mid-Levels are similar to Physicians

Summary of Changes - Continued

Policy No./ Name	Summary of Changes	Reason for Change
GG.1650 Credentialing and Re-credentialing of Practitioners (continued)	▪ Clarified types of practitioners that are credentialed and not credentialed. ▪ Final decisions will be rendered within 180 days from date of licensure verification. ▪ Added reference to GG.1643: Minimum Physician Standards. ▪ Work history verified including all post-graduate activity in the last five years.	•Alignment to DHCS APL • Per NCQA standards • Reference to new policy added 7/1/2016 • Process follows industry business practice

Summary of Changes - Continued

Policy No./ Name	Summary of Changes	Reason for Change
GG.1651 Credentialing and Re-credentialing of Health Delivery Organizations (HDOs) (New Policy)	▪ Policy specific to HDOs such as hospitals, home health agencies, skilled nursing facilities, and free standing surgical centers. ▪ Aligns to new DHCS APL for: ▪ Provider types (non-practitioner) ▪ Categorizing providers by risk-level ▪ Additional requirements for moderate and high risk providers ▪ HDO credentialing requirements: ▪ Confirms if provider is in good standing ▪ Confirms review and approved by accredited body ▪ Conducts on-site quality assessment if not accredited	• Credentialing specific to HDO's • Alignment with DHCS APL 16-012 • Alignment to NCQA Standard CR7

Summary of Changes - Continued

Policy No./ Name	Summary of Changes	Reason for Change
GG.1607 Monitoring of Adverse Activities	▪ Describes the monthly monitoring of adverse activities for practitioners, HDO's and other contracted and non-contracted providers.	• Align with current business practices.
	▪ Specifies the various activities that are monitored, including but not limited to OIG, SAM, NPDB, Medicare Opt-Out, Medi-Cal Provider Suspended and Ineligible list, Medical Board of California	• Added SAM requirement for Medicare
	▪ Updated reporting requirements to DHCS and Health Networks when adverse activities are identified	• Align with DHCS APL

Summary of Changes - Continued

Policy No./ Name	Summary of Changes	Reason for Change
GG.1616 Fair Hearing	▪Describes the process CalOptima uses to provide a fair procedure to Practitioners when adverse actions are proposed or taken by CalOptima. ▪Differentiates CalOptima initiated actions vs. practitioner initiated actions vs. other disciplinary actions ▪Delineates actions as a result of medical disciplinary versus administrative cause or reason, and handles fair hearing rights specific to medical disciplinary cause or reason.	• Added more specificity and appropriate legal language to the fair hearing procedure and policy

Summary of Changes - Continued

Policy No./ Name	Summary of Changes	Reason for Change
GG.1633 Board Certification Requirements for Physicians	▪Describes the requirements for board certification of contracted physicians ▪ Added specific language to address specialties with shorter or longer board certification time periods, such as podiatric physician board certification ▪Added language to align~~ed~~ with Minimum Physician Standards policy GG.1643 effective July 1, 2016 ▪ Added language to clarify exemption and grandfathering for certain contracted physicians who meet specific requirements	• Updated policy to include board certification requirements for Podiatrists • Added Reference to GG.1643 Minimum Physician Standards

Policy #:	GG.1650Δ
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/17
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy defines the process by which CalOptima evaluates and determines whether to approve or decline practitioners (as described in Section II. of this Policy ("Practitioners")) for participation in CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines by which CalOptima shall evaluate and select Practitioners to participate in CalOptima, in accordance with Title 42, Code of Federal Regulations, Section 422.204(a) and other applicable laws, regulations, and guidance.

B. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Health Network shall establish policies and procedures to evaluate and approve Practitioners to participate in CalOptima programs that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO), or his or her physician Designee, shall have direct responsibility over and actively participate in the Credentialing program.

D. The CalOptima Credentialing Peer Review Committee (CPRC) shall be responsible for reviewing a Practitioner's Credentialing information and determining such Practitioner's participation in CalOptima.

E. CalOptima shall Credential and Recredential the following Practitioners as provided in this Policy Physicians, Non-Physicians Medical Practitioners, Behavioral Health Practitioners, Substance Use Disorder (SUD) Practitioners, and Long Term Services and Supports (LTSS) Practitioners that provide care to CalOptima program Members, and are:

1. Licensed, certified, or registered by the state of California to practice independently and;

2. Contracted with CalOptima including physicians practicing at Federally Qualified Health Centers (FQHC) and community clinics that perform Primary and Specialty Care services.

DRAFT

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F. CalOptima shall credential Non-Physician Medical Practitioners (NMP) who do not have an independent relationship with CalOptima, as follows:

1. For NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner who has executed a signed Delegation Services Agreement with the NMP; or

2. Under the employment agreement of a credentialed Provider.

G. An NMP shall notify CalOptima immediately if the supervising Physician Practitioner no longer meets the CalOptima Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or employment with the entity.

H. CalOptima does not Credential or Recredential:

1. Practitioners that practice exclusively within the inpatient setting (e.g., Hospitalist) and provide care for a Member only as a result of the Member being directed to the hospital, or inpatient, setting;

2. Practitioners that practice exclusively within freestanding facilities, and provide care for a Member only as a result of the Member being directed to the facility (e.g. Diagnostic Radiologists, Urgent Care, Emergency Medicine);

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima delegates utilization management (UM) functions (Credentialing of Pharmacies and its professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access.);

4. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with CalOptima;

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., External Physician Reviewer); and

I. CalOptima shall categorize Practitioners into the three (3) Fraud, Waste, and Abuse risk levels established by the Centers for Medicare & Medicaid Services: limited, moderate, and high, and will screen Practitioners for the appropriate risk level in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 16-012: Provider Credentialing and Recredentialing, Title 42, CFR, Section 455, and as described Sections III.A. and III.B. of this Policy.

J. CalOptima shall Recredential a Practitioner at least every three (3) years, utilizing a thirty-six (36)-month cycle to the month, not to the day.

K. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles and shall provide evidence of monthly review of the Medical Board of California and Office of Inspector General (OIG) exclusion, or suspension, list in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Activities.

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L. If CalOptima declines to include a Practitioner in the CalOptima network, CalOptima shall notify, in writing, such Practitioner within sixty (60) calendar days of the reason for its decision.

M. CalOptima shall not discriminate, in terms of participation, reimbursement, or indemnification, against any Practitioner who is acting within the scope of his or her license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima from:

1. Refusing to grant participation to a Practitioner in excess of the number necessary to meet the needs of Members;

2. Using different reimbursement amounts for different specialties, or for different Practitioners in the same specialty; and

3. Implementing measures designed to maintain quality and control costs consistent with CalOptima's responsibilities.

N. CalOptima shall not discriminate against a Practitioner that serves high-risk populations, or specializes in the treatment of costly conditions.

O. CalOptima shall not make, or decline, Credentialing and Recredentialing decisions based on a Practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient, in which the Practitioner specializes.

P. CalOptima shall monitor and prevent discriminatory Credentialing decisions as follows:

1. Periodic audits of Credentialing files (in-process, denied, and approved files) to ensure Practitioners are not discriminated against at least annually;

2. Periodic audits of Practitioner complaints to determine if there are complaints alleging discrimination, including a review by the CPRC of quarterly reports of complaints, including discrimination at least annually;

3. Maintaining a heterogeneous Credentialing committee membership; and

4. Requiring those responsible for Credentialing and Recredentialing decisions to sign a statement affirming that they do not discriminate when making decisions.

Q. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

R. CalOptima shall maintain Credentialing files that include documentation of required elements, as described in this Policy.

S. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

1. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing, or Recredentialing process, the application shall be considered expired.

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T. Except as provided in CalOptima Policy GG.1608Δ: Full Scope Site Reviews, CalOptima does not delegate the Facility Site Review and Medical Record Review (MRR) processes to a Health Network. CalOptima assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

U. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. In conjunction with the CalOptima Provider Relations and Contracting Departments, a Practitioner shall initiate the Credentialing process with CalOptima.

   a. Upon receipt of the request from the Practitioner, CalOptima shall send a notification electronically, explaining the expectations for completion and submission of the credentialing application and required documents.

   b. Physician Practitioners shall meet the Minimum Physician Standards as outlined in CalOptima Policy GG.1643Δ: Minimum Physician Standards and CalOptima will verify that the Physician Practitioner meets the minimum standards as provided in this Policy.

   c. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima that attests to:

      i. Any work history gap that exceeds six (6) months, including written clarification;

      ii. The essential functions of the position that the Practitioner cannot perform, with or without accommodation (i.e., health status);

      iii. Lack of present illegal drug use that impairs current ability to practice;

      iv. History of any loss of license and history of felony convictions;

      v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

      vi. Current malpractice insurance coverage; and

      vii. The correctness and completeness of the application;

   d. All credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

   e. A Practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

   f. CalOptima shall return an incomplete application to a Practitioner, and such incomplete application will not be processed until the Practitioner submits all the required information.

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g. An NMP who does not have an individual relationship with CalOptima, and is supervised by a Physician Practitioner, must include a signed Delegation Services Agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima, or provide a copy of the employment agreement with the credentialed provider.

2. Upon receipt of a complete Credentialing application, CalOptima shall verify the information provided through primary verification using industry-recognized verification sources or a Credentialing Verification Organization. This information includes, but is not limited to:

   a. A current, valid California license to practice in effect at the time of the Credentialing decision;

   b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians; and

   c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements and if applicable, completion of residency, and specialty training.

3. CalOptima shall also collect and verify the following information from each Provider as applicable, but need not verify this information through a primary source. This information includes, but is not limited to:

   a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The Practitioner shall provide, in writing, an explanation of any gaps of six (6) months, or more;

   b. Written, or verbal, confirmation from the Practitioner's primary inpatient admitting facility that the Practitioner has privileges in good standing, or confirmation that the Practitioner refers patients to hospital-based Practitioners (Hospitalist), as applicable;

   c. Any alternative admitting arrangements must be documented in the Credentialing file;

   d. A valid DEA, or Controlled Dangerous Substances (CDS), certificate obtained through confirmation by National Technical Information Service (NTIS), if applicable, in effect at the time of the Credentialing decision;

   e. A valid National Provider Identifier (NPI) number;

   f. Current malpractice insurance or self-insurance (e.g., trust, escrow accounts coverage) in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision;

   g. Practitioner information entered into the National Practitioner Data Bank (NPDB), if applicable;

   h. No exclusion, suspension, or ineligibility to participate in any state and federal health care program at the time of the Credentialing decision;

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i. A review of any Grievances, or quality, cases filed against a Practitioner in the last three (3) years;

j. No exclusion from participation at any time in federal, or state, health care programs based on conduct within the last ten (10) years that supports a mandatory exclusion under the Medicare program, as set forth in Title 42, United States Code, Section 1320a-7(a), as follows:

i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

ii. A felony conviction related to neglect, or abuse, of patients in connection with the delivery of a health care item, or service;

iii. A felony conviction related to health care Fraud; or

iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

k. History of professional liability claims that resulted in settlements or judgments, paid by, or on behalf of, the Practitioner;

l. Human Immunodeficiency Virus (HIV) specialist attestation, if applicable;

m. Current IRS Form W-9;

n. Current (within last three (3) years) Full Scope FSR/MRR, and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews; and

o. Active enrollment status with Medi-Cal

i. The CMO, or his or her physician Designee, has the ability to make exceptions with respect to Medi-Cal enrollment status in order to satisfy access and continuity of care requirements; and

ii. The CMO, or his or her physician Designee, may also make exceptions to Providers outside of Orange, Los Angeles, San Bernardino, Riverside, and San Diego Counties, on a case-by-case basis.

p. Active enrollment status with Medicare for OneCare, or OneCare Connect, Practitioners.

B. Practitioner Recredentialing

1. CalOptima shall Recredential a Practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima shall:

a. Collect and verify, at a minimum, all of the information required for initial credentialing, as set forth in Section III.A of this policy, including any change in work history, except historical data already verified at the time of the initial credentialing of the Practitioner; and

b. Incorporate the following data in the decision-making process:

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i. Member Grievances and Appeals, including number and type during the past three (3) years;

ii. Information from quality review activities;

iii. Board Certification, if applicable;

iv. Member satisfaction, if applicable;

v. Medical Record Reviews, if applicable;

vi. Facility Site Review (FSR) results and Physical Accessibility Review Survey (PARS) results, if applicable; and

vii. Compliance with the terms of the Practitioner's contract.

c. All Recredentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) Full Scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

3. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles.

4. If CalOptima terminates a Practitioner during the Recredentialing process for administrative reasons (i.e., the Practitioner failed to provide complete credentialing information) and not for quality reasons (i.e., medical disciplinary cause or reason), it may reinstate the Practitioner within thirty (30) calendar days of termination and is not required to perform initial credentialing. However, CalOptima must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima must perform initial credentialing of such Practitioner.

C. Practitioner Rights

1. New applicants for Credentialing will receive Practitioner Rights attached to the CPPA as Addendum A, describing the following:

a. Right to review information

i. Practitioners will be notified of their right to review information CalOptima has obtained to evaluate their credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure.

b. Right to correct erroneous information

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i. All Practitioners will be notified by certified mail when Credentialing information obtained from other sources varies substantially from that provided by the Practitioner;

ii. All Practitioners have the right to correct erroneous information, as follows:

a) The Practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by certified mail on the Practitioner's letterhead with a detailed explanation regarding erroneous information, as well as copy(ies) of corrected information; and

c) All submissions will be mailed to CalOptima's Quality Improvement Department using the following address:

Attention: Quality Improvement Department – Credentialing
CalOptima
505 City Parkway West
Orange, CA 92868

iii. CalOptima is not required to reveal the source of information, if the information is not obtained to meet CalOptima's Credentialing verification requirements, or if federal or state law prohibits disclosure.

2. Documentation of receipt of corrections

a. A Practitioner shall be notified within thirty (30) calendar days via a letter to document CalOptima's receipt of the identified erroneous information.

3. Right to be notified of application status

a. Practitioners may receive the status of their Credentialing, or Recredentialing, application, upon request.

b. Practitioners can contact the Quality Improvement Department by phone, e-mail, or facsimile requesting the status of their application. The Quality Improvement Department will respond within one (1) business day of the status of the Practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Such CPRC shall include representation from a range of Practitioners participating in the organization's network, and shall be responsible for reviewing a Practitioner's Credentialing and Recredentialing files, and determining the Practitioner's participation in CalOptima programs.

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3. Completed Credentialing and Recredentialing files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

    a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no professional review or malpractice claim(s) that resulted in settlements or judgments paid by, or on behalf of, the Practitioner within the last seven (7) years from the date of the Credentialing, or Recredentialing, review

        i. A clean file shall be considered approved and effective on the date that the CMO, or his or her physician Designee, review and approve a Practitioner's Credentialing, or Recredentialing, file, and deem the file clean.

        ii. Approved, clean file lists shall be presented at the CPRC and reflected in the meeting minutes.

    b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of malpractice claim(s) that resulted in settlements or judgments paid by, or on behalf of, the Practitioner, identification of Practitioner, or OIG exclusion list, Medi-Cal Suspended and Ineligible Provider List, or NPDB query identifying Medical Board investigations, or other actions.

        i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

        ii. CPRC minutes shall reflect thoughtful consideration of information presented in the credentialing file.

        iii. CPRC meetings and decisions may take in real-time, as a virtual meeting, but may not be conducted through e-mail.

4. The CPRC shall make recommendations based on the Practitioners' ability to deliver care based on the Credentialing information collected from the file review process, and shall be verified prior to making a Credentialing decision.

    a. The Quality Improvement Department shall send the Practitioner a decision letter, within sixty (60) calendar days of the decision:

        i. Acceptance;

        ii. Acceptance with Restrictions along with appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners; or

        iii. Denial of the application along with appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

    b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

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i. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing, or Recredentialing process, the application shall be considered expired.

E. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:

a. Monitoring:

i. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that Practitioners are not discriminated against; and

ii. Review Practitioner complaints to determine if there are complaints alleging discrimination.

iii. On a quarterly basis, the QI Department shall review grievances, appeals, and potential quality of care issues for complaints alleging discrimination, and will report outcomes to the CPRC for review and determination.

b. Prevention:

i. The QI Department shall maintain a heterogeneous Credentialing committee, and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

F. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Credentialing data into CalOptima's core business system, which updates pertinent information into the online Provider directory.

IV. ATTACHMENTS

A. California Participating Physician Application (CPPA)
B. CalOptima Primary Source Verification Table
C. Ongoing Monitoring Website Information Matrix

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima PACE Program Agreements
D. CalOptima Contract for Health Care Services2017 NCQA Standards and Guidelines
E. CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access
F. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy GG.1606Δ: Credentialing and Recredentialing of Mid-Level Practitioners
I. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
J. CalOptima Policy GG.1608Δ: Full Scope Site Reviews

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K. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
L. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
M. CalOptima Policy GG.1643Δ: Minimum Physician Standards
N. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of a Healthcare Delivery Organization (HDO)
O. CalOptima Policy HH.1101: CalOptima Provider Compliant
P. CalOptima Policy MA.9006: Provider Complaint Process
Q. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
R. Department of Health Care Services All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit
U. Department of Health Care Services All Plan Letter (APL) 16-012: Provider Credentialing and Recredentialing
S. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 438.12, 438.214, 460.64 and 460.71
T. Title 45, Code of Federal Regulations, §455, Subpart E
U. Title 42, United States Code, §1320a-7(a)
V. Title XVIII and XIV of the Social Security Act
W. California Business and Professions Code, Section 805
X. California Evidence Code, Section 1157

VI. REGULATORY AGENCY APPROVALS

A. 04/28/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 06/01/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/1996	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	02/1998	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	01/1999	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	08/2000	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	02/2001	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	01/01/2006	MA.7009	Credentialing and Recredentialing	OneCare
Revised	07/01/2007	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	07/01/2009	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2011	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	03/01/2012	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2013	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	06/01/2014	GG.1609	Credentialing and Recredentialing	Medi-Cal

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Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	02/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Revised	03/01/2015	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Effective	06/01/2017	GG.1650Δ	Credentialing and Recredentialing	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.
Appeal	A request by the Member or the Member's Authorized Representative for review of any decision to deny, modify, or discontinue a Covered Service.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing Peer Review Committee	Peer review body who reviews all recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization	An organization that collects and verifies credentialing information.
Delegation Services Agreement	Mutually agreed upon document, signed by both parties, which includes, without limit: 1. CalOptima responsibilities; 2. Duration of the agreement; 3. Termination of the agreement; 4. Delegated Entity responsibilities and Delegated Services; 5. Types and frequency of reporting to the Delegated Entity; 6. Process by which the CalOptima evaluates the Delegated Entity's performance (Performance Measurements); 7. Use of confidential CalOptima information including Member Protected Health Information (PHI) by the Delegated Entity; and 8. Remedies available to the CalOptima if the Delegated Entity does not fulfill its obligations.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

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Term	Definition
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. § 1347).
Full Scope Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.
Grievance	An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.
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.
Long Term Support Services (LTSS) Provider	A licensed practitioner such as physicians, Non-Physician Medical Practitioners (NMP), social workers, and nurse managers.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An enrollee-beneficiary of a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed 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), furnishing covered services.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a Primary Care Provider (PCP).
Recredentialing	The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, Specialty Care given to Members by referral by other than a Primary Care Provider (PCP).

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Term	Definition
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one (1) of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.
Utilization Management (UM)	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
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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California Participating Practitioner Application

I. Instructions

This form should be typed. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please refer to cover page for a list of the required documents to be submitted with this application.

II. Identifying Information

Last Name: First Name: Middle:

Is there any other name under which you have been known? Name(s):

Home Mailing Address:

City: State: Zip Code:

Home Phone Number: Fax Number: Cell Number: Pager Number:

Practitioner Email: Citizenship (If not a U.S. citizen, please provide a copy of Alien Registration Card):

Birth Date: Social Security Number:

Birth Place: Gender ○ Male ○ Female

Driver's License State/Number: Race/Ethnicity (optional):

Your intent is to serve as a(n):

☐ Primary Care Provider ☐ Specialist ☐ Urgent Care ☐ Hospitalist ☐ Hospital Based

Specialty:

Subspecialties:

III. Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Primary Office Address:

City: State: Zip Code:

Telephone Number: Fax Number: Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number:

Office Administrator/Manager Email: Office Administrator/Manager Fax Number:

Federal Tax ID Number: Name Associated with Tax ID:

III. Practice Information (Continued)

Please identify the physical accessibility of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Primary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #: Group NPI #:

Secondary Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Secondary Office Address:

City: State: Zip Code:

Telephone Number: Fax Number: Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number:

Office Administrator/Manager Email: Office Administrator/Manager Fax Number:

Federal Tax ID Number: Name Associated with Tax ID:

Please identify the physical accessibility of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Secondary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #: Group NPI #:

Tertiary Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Tertiary Office Address:

City: State: Zip Code:

Telephone Number: Fax Number: Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number:

Office Administrator/Manager Email: Office Administrator/Manager Fax Number:

Federal Tax ID Number: Name Associated with Tax ID:

Please identify the physical accessibility of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Tertiary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #: Group NPI #:

Mailing Address

Which of your practices is your primary mailing address? ◯ Primary ◯ Secondary ◯ Tertiary ◯ Other

If your mailing address is different from your practice address, please provide it:

IV. Billing Information

Which of your practices handles your billing? ◯ Primary ◯ Secondary ◯ Tertiary If none, please provide billing information:

Billing Company

Billing Company Mailing Address:

City: State: Zip Code:

Contact Person: Telephone Number:

Federal Tax ID Number: Name Associated with Tax ID:

V. Practice Description

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologist, etc.)? ◯ Yes ◯ No
If so, please list:

Name	Type of Provider	License Number

Physician Assistant Supervisor Name: License Number:

Do you personally employ any physicians (do not include physicians who are employed by the medical group)? ◯ Yes ◯ No
If so, please list:

Name	**California Medical License Number**	**Primary/Secondary/Tertiary Practice**
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you perform that are not typically associated with your specialty:

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you do **not** perform that are typically associated with your specialty:

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Is your practice limited to certain ages? ◯ Yes ◯ No If yes, specify limitation:

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Coverage of Practice

List your answering service and covering physicians by name. Attach additional sheets if necessary.

Answering Service Company

Answering Service Mailing Address:

City: State: Zip Code: Email:

Covering Physician's Name(s) / Phone Number / Which practices does their coverage apply (Primary, Secondary, Tertiary):

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VI. Education, Training and Experience

Medical/Professional Education NOT REQUIRED FOR RE-CREDENTIALING

Medical School/Professional: | Degree Received: | Graduation Date:

Mailing Address: | Website (if applicable):

City: | State: | Zip Code: | Registrar's Phone Number:

Internship/PGY-1 NOT REQUIRED FOR RE-CREDENTIALING

Institution: | Program Director:

Address | City | State | Zip

Telephone Number: | Fax Number: | Website (if applicable):

Type of Internship: | From (mm/yyyy): | To (mm/yyyy):

Did you successfully complete the program? ◯ Yes ◯ No (If No, please explain on a separate sheet.)

Residencies/Fellowships For Re-Credentialing, please add any new Residencies or Fellowships in the last three (3) years.

Institution: | Program Director:

Address | City | State | Zip

Telephone Number: | Fax Number: | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) | To(mm/yy):

Institution: | Program Director:

Address | City | State | Zip

Telephone Number: | Fax Number: | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) | To(mm/yy):

Institution: | Program Director:

Address | City | State | Zip

Telephone Number: | Fax Number: | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) | To(mm/yy):

VII. Medical Licensure & Certifications

California State Medical License Number	Issue Date	Expiration Date

Drug Enforcement Agency (DEA) Registration Number	Schedules	Expiration Date

Controlled Dangerous Substances Certificate (CDS) (if applicable)	Expiration Date

ECFMG Number (applicable to foreign medical graduates)	Issue Date

Individual National Physician Identifier (NPI)	Medi-Cal/Medicaid Number	Individual Medicare PTAN Number

All Other State Medical Licenses

State	License Number	Issue Date	Expiration Date

Other Certifications (e.g., Fluoroscopy, Radiography, ACLS/BLS/PALS, etc.)

Type of Certification	License Number	Expiration Date

Board Certification(s)

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board	Certificate Number	Date Certified/Recertified	Expiration Date (if any)

Board Certification(s) (Continued)

Have you applied for board certification other than those indicated on the prior page? ◯ Yes ◯ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification below or in a separate sheet.

Specialty:

Board Name:

Exam Date:

Describe here:

VIII. Current Hospital and Other Institutional Affiliations

Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B). This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

A. Current Affiliations

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Primary Hospital Address:

City: State: Zip Code: From (mm/yy):

Medical Staff Phone: Medical Staff Fax: To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Secondary Hospital Address:

City: State: Zip Code: From (mm/yy):

Medical Staff Phone: Medical Staff Fax: To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: State: Zip Code: From (mm/yy):

Medical Staff Phone: Medical Staff Fax: To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: State: Zip Code: From (mm/yy):

Medical Staff Phone: Medical Staff Fax: To (mm/yy):

A. Current Affiliations (continued)

If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):

B. Previous Hospital and Other Institution Affiliations

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

IX. Peer References

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations. **At least one reference must be from someone with the same credentials, for example, a MD must list a reference from another MD or a DPM must list one reference from another DPM.**

Name of Reference: Specialty:

Address City State Zip

Telephone Number: Fax Number: Email Address:

Name of Reference: Specialty:

Address City State Zip

Telephone Number: Fax Number: Email Address:

Name of Reference: Specialty:

Address City State Zip

Telephone Number: Fax Number: Email Address:

X. Work History

For Re-Credentialing, check box if no changes in the last three (3) years.

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. Curriculum vitae are <u>not</u> sufficient. Please explain any gaps on a separate page.

Current Practice: Contact Name:

Address City State Zip

Telephone Number: Fax Number: From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip

Telephone Number: Fax Number: From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip

Telephone Number: Fax Number: From (mm/yy): To (mm/yy):

XI. Professional Liability

Please list all of your professional liability carriers for the past five years, listing the most recent first. If more space is needed, attach additional sheet(s).

Name of Current Insurance Carrier: Policy Number:

Address City State Zip

Telephone Number: Fax Number: Website (if applicable):

Email Address: Tail Coverage? ◯ Yes ◯ No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

Name of Carrier: Policy Number:

Address City State Zip

Telephone Number: Fax Number: Website (if applicable):

Email Address: Tail Coverage? ◯ Yes ◯ No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

Name of Carrier: Policy Number:

Address City State Zip

Telephone Number: Fax Number: Website (if applicable):

Email Address: Tail Coverage? ◯ Yes ◯ No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

XII. Professional and Practice Services

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? ◯ Yes ◯ No

What type of anesthesia do you provide in your group/office?

☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify)

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver.

Federal Tax ID: Type of Service Provided: Do you have a CLIA certificate? ◯ Yes ◯ No

Billing Name: Do you have a CLIA waiver? ◯ Yes ◯ No

CLIA Certificate Number: CLIA Certificate Expiration Date:

XII. Professional and Practice Services (continued)

Have you or your office received any of the following accreditations, certificates or licensures?

- ☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- ☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
- ☐ Medicare Certification
- ☐ The Medical Quality Commission (TMQC)
- ☐ Child Health and Disability Prevention Program (CHDP)
- ☐ Comprehensive Perinatal Services Program (CPSP)
- ☐ California Children Services (CCS)
- ☐ Family Planning
- ☐ Other

Please list international, state and/or national medical societies or other professional organizations or societies of which you are a member or applicant. Use the drop-down list to select your membership status.

Organization Name	Membership Status

Do you participate in electronic data interchange (EDI)? ○ Yes ○ No If so, which Network?

Do you use a practice management system/software? ○ Yes ○ No If so, which one?

Continue to the Next Page for HIV/AIDS Specialist Designation

HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine. **OR**

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties. **OR**

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**

2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; **OR**

2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**

3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Continue to the Next Page for Attestation

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending? ◯ Yes ◯ No

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending? ◯ Yes ◯ No

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs), or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ◯ Yes ◯ No

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ◯ Yes ◯ No

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? ◯ Yes ◯ No

6. Have you ever been denied certification/recertification by a specialty board? ◯ Yes ◯ No

7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation? ◯ Yes ◯ No

8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? ◯ Yes ◯ No
   b. Are any such actions pending? ◯ Yes ◯ No

9. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If **YES**, please complete Addendum B. ◯ Yes ◯ No

10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? If **YES**, please complete Addendum B. ◯ Yes ◯ No

11. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? ◯ Yes ◯ No

12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If **YES**, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. ◯ Yes ◯ No

Continue to the Next Page for Additional Attestation

ATTESTATION QUESTIONS (Continued)

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. ○ Yes ○ No

    If **YES**, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ○ Yes ○ No

14. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs? ○ Yes ○ No

15. Within the last two (2) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ○ Yes ○ No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

APPLICANT SIGNATURE (Stamp is Not Acceptable)	PRINTED NAME	DATE

Continue to the Next Page for Information Release/

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents - collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, within fourteen (14) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

APPLICANT SIGNATURE (Stamp is Not Acceptable)	**PRINTED NAME**	**DATE**

Addenda Submitting :

☐ Addendum B: Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:
- California Association of Health Plans (916) 552-2910
- California Association of Physician Groups (916) 443-2274

The CPPA has been completed. Please be sure you have signed the last two pages (pages 15 and 16) before submission.

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.

The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of your application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correct will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address:					
City:		ST:		Zip:	

APPLICANT SIGNATURE **PRINTED NAME** **DATE**

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California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to _____ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise conclude professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

☐ *Please check here if there are no pending/settled claims to report (and sign below to attest).*

I. Practioner Identifying Information

Last Name: _____ First Name: _____ Middle: _____

II. Case Information

Patient's Name: _____ Patient Gender ○ Male ○ Female Patient DOB: _____

City, County, State where lawsuit filed: _____ Court Case number, if known: _____ Date of alleged incident serving as basis for the lawsuit/ arbitration: _____ Date suit filed: _____

Location of incident:
☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify) _____

Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.) _____

Allegation

_____

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ○ Yes ○ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

_____

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name: _____ Telephone Number: _____ Fax Number: _____

III. Status of Lawsuit/Arbitration (check one)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: $

☐ Judgment rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: $

☐ Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:
1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

APPLICANT SIGNATURE **PRINTED NAME** **DATE**

CalOptima Primary Source Verification Table

Primary Source Verification – Licensure

Licensure	Source of Verification	Method of Documentation
MD – Medical Board of California	www.mbc.ca.gov AIM screen with Facility log-in	Full print out indicating "data current as of" and the accessed date at bottom of the print out
DO- Osteopathic Board of California	www.ombc.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
DC- California Board of Chiropractic	www.chiro.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
DDS- Dental Board of California	www.dbc.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
DPM- California Board of Podiatric Medicine	www.bpm.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
California Board of Psychology	http://www.psychology.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
California Board of Behavioral Sciences	http://www.bbs.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
Department of Consumer Affairs Acupuncture Board	http://www.acupuncture.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
Department of Consumer Affairs CA State Board of Optometry	http://www.optometry.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out

CalOptima Primary Source Verification Table

Primary Source Verification- DEA

DEA	Source of Verification	Method of Documentation
DEA	NTIS https://www.deanumber.com	Full print out indicating "data current as of"
	https://www.deadiversion.usdoj.gov (or)	Print out
	AMA Physician Master File	Visual inspection/ print out
	Copy of current DEA certificate	

Primary Source Verification – Board Certification

Board Certification	www.Boardcertifieddocs.com (or)	Print out
	https://www.doprofiles.org/	Print out
	American Board of Podiatric Surgery	Print out
	http://www.abps.org/	

Primary Source Verification- Education & Training

Education & Training	Source of Verification	Method of Documentation
Education & Training	Board certification by ABMS or AOA in practicing specialty	Print out certificate
	AMA Physician Master File http://profiles.ama-assn.org	Print out of AMA with education "verified" not "being verified" or "being re-verified" ; Print out
	(or)	
	AOA Official Osteopathic Physician Profile Report https://www.doprofiles.org/	AOA Profile
	(or)	
	Contact the training institution to verify the highest level of training.	Letter from institution stating that practitioner successfully completed the training in good standing or provide an explanation if the practitioner was ever disciplined.
	State Licensing Agency, as applicable	

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CalOptima Primary Source Verification Table

Primary Source Verification – Malpractice History

Malpractice History	NPDB-HIPDB Http://www.npdb-hippdb.hrsa.gov	Print out of report

Primary Source Verification- Medicare/Medicaid Sanctions

Sanction Information	Source of Verification	Method of Documentation
State & Federal Sanctions	NPDB-HIPDB Http://www.npdb-hippdb.hrsa.gov (and)	Print out of report
	System for Award Management http://www.sam.gov (and)	Information entered in Credentialing Data Base and print out included in the credentialing packet
	Office of Inspector General http://oig.hhs.gov (and)	Information entered in Credentialing Data Base and print out included in the credentialing packet
	Medi-Cal Suspended & Ineligible List http://files.medi-cal.ca.gov/	Information entered in Credentialing Data Base and print out included in the credentialing packet
	AMA Physician Master File AOA Physician Profile report	In credentialing file (if used for verification of another element) In Credentialing file
	State Licensing agencies	

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 PH:(916) 263-2382 or (800) 633-2322 Enforcement Central File Room PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord. (916) 263-2449	MD	**www.mbc.ca.gov** **All communications for disciplinary actions will be done by e-mail to subscribers.** **Link to subscribe for actions:** **http://www.mbc.ca.gov/Subscribers/** **Link for all Disciplinary Actions/License Alerts distributed:** **http://www.mbc.ca.gov/Publications/Disciplinary_Actions/** **Enforcement Public Document Search (Search by Name or Lic:** **http://www2.mbc.ca.gov/PDL/Search.aspx**	You must signup to subscribe for E-mail notifications of accusations, license suspensions, restrictions, revocations, or surrenders for physicians and surgeons licensed by the MBOC. Disciplinary action documents are obtainable via the web-site by: • Link to Enforcement Public Document Search (on the left side of page under check your doctor online) or in the • License verification section; Under Public Documents – Top Right	Bi-Monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final
Osteopathic Medical Board of CA 1300 National Drive, Suite #150 Sacramento, CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax E-mail:osteopathic@dca.ca.gov Enforcement/Disciplines(916)-928-8390 Ext. 6	DO	**www.ombc.ca.gov** **Direct Link To Enforcement Actions:** **http://www.ombc.ca.gov/consumers/enforce_action.shtml** **Subscribe to e-mail Alerts** **http://www.ombc.ca.gov/consumers/enforce_action.shtml**	▪ Link to Consumers Tab at the top ▪ Link to Enforcement Action Can get on a distribution list by e-mailing J. Corey Sparks, Lead Enforcement Analyst E-mail: Corey.Sparks@dca.ca.gov 916-928-8393 (PH) 916-928-8392 (FAX) The board is behind in updating the website. You can subscribe or send an e-mail to get on the distribution list. 01/18/17 – 2nd Quarter 2016 is the last posted report. E-mails distribution is current	Quarterly via the Website E-Mail Distribution list:

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Medical Board of California **Board of Podiatric Medicine** 2005 Evergreen Street, Ste. 1300 Sacramento, CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651 Email: BPM@dca.ca.gov Enforcement Program Central File Room Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 FAX: (916) 263-2420	DPM	**www.bpm.ca.gov** **Direct Link toEnforcement Resources:** **http://www.bpm.ca.gov/consumers/index.shtml** **Subscribers list** **http://www.mbc.ca.gov/Subscribers/** .	▪ Consumers ▪ Link to Enforcement Resources ▪ Link to Recent Disciplinary Actions(Categorized by the following): ➢ Decisions ➢ Accusations Filed ➢ Accusation and Petition to Revoke Probation filed ➢ Accusations and/or Statement of Issues Withdrawn or Dismissed ➢ Statement of Issues Listed alphabetically by category: Decision, Accusation, etc. 9/21/16 was the latest update on 12/15/16 and no reports were available. Updated01/17/17	Board of Podiatric Medicine: Changes to viewing information. On the website go to recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. History not available only current accusations and decisions latest one year from effective date. You can subscribe to actions related to licenses
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento, CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204 Email: acupuncture@dca.ca.gov To order copies of actions send to Attn of Consumer Protection Program	LAC/AC	**www.acupuncture.ca.gov** **Direct Link to Disciplinary Actions:** **www.acupuncture.ca.gov/consumers/board_actions.shtml** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/acupuncture/subscribe.php**	▪ Link to Consumer at the top ▪ Link to DisciplinaryActions Last update January 5, 2017	Monthly running report listed Alpha Newer actions highlighted with date in blue. Note: Board meetings are held quarterly.

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Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625 E-Mail: BBSWebmaster@bbs.ca.gov	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	**www.bbs.ca.gov** **Sign up for subscribers list for disciplinary actions.** **https://www.dca.ca.gov/webapps/bbs/subscribe.php**	You must sign up for Subscriber list to obtain Enforcement Actions. E-mail will be sent to you. If you don't sign up as a subscriber, the News Letters will provide disciplinary actions.	**Via Subscriptions Only** Information must be obtained via subscription. For Subscribers: E-mail reports were sent:
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street, Suite 142A Sacramento, CA 95814 PH (916) 263-5355 FAX (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	**www.chiro.ca.gov** **Monthly Reports** **http://www.chiro.ca.gov/enforcement/actions.shtml**	Note monthly disciplinary actions reports ▪ Link to Enforcement at the top right side (next to Contact Us) ▪ Link to Disciplinary Actions ▪ Actions listed by month and year Last report December 2016	Monthly
Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 PH: (916) 263-2300 PH: (877)729-7789 Toll Free Fax #: (916) 263-2140 Email:dentalboard@dca.ca.gov Enforcement Unit PH: 916-274-6326	DDS, DMD	**www.dbc.ca.gov** **Direct Link to Disciplinary Actions:** **http://www.dbc.ca.gov/consumers/hotsheets.shtml**	▪ Link Home Page ▪ Under Highlights at the bottom of the page-Link to Hot Sheet! Dental Disciplinary Action ▪ Actions listed by month and year Or ▪ Link to Consumer ▪ Hot Sheets (Summary of Administrative Actions Last report December 2016	Monthly Note: At the end of the list it provides a date posted. As of 12/31/2016

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Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento, CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701 Email: cbot@dca.ca.gov Email: EnfPrg@dca.ca.gov	OT, OTA	**www.bot.ca.gov** **Direct Link To Enforcement Actions:** **http://www.bot.ca.gov/consumers/disciplinary_action.shtml** **Sign up for subscribers list for disciplinary actions: https://www.dca.ca.gov/webapps/bot/subscribe.php**	▪ Link to Consumer at the top ▪ Link to Disciplinary Action Practitioners are listed under: Revocations, Surrenders and Other Disciplinary Orders: A – L and M – Z. **Sign up to receive a monthly Hot Sheet List of disciplinary actions via e-mail to:** EnfPrg.Enfprg@dca.ca.gov Will need to send a written request to obtain the information, which may be sent back to you via e-mail.	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action. E-Mail Submission
California State Board of Optometry 2450 Del Paso Road, Suite 105 Sacramento, CA 95834 PH:(916) 575-7170 Fax (916) 575-7292 Email: optometry@dca.ca.gov	OD	**www.optometry.ca.gov** **Direct Link To Enforcement Actions:** **http://www.optometry.ca.gov/consumers/disciplinary.shtml**	▪ Link to Consumer at the top ▪ Link to Citations and Disciplinary Actions ▪ Bottom of page actions are posted by year Practitioners are listed by year, type of action and then alphabetically Note: Report provides a Last Updated date at the top of the report. Last update12/22/2016	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. Recommend monthly review. The Board typically adopts formal disciplinary actions during regularly scheduled quarterly meetings.

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento, CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	**www.ptb.ca.gov** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/ptbc/interested_parties.php**	Disciplinary action and license reinstatement information may be obtained by checking the Board's online license verification system. Last update 9/28/15	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
Physician AssistantBoard (PAB) 2005 Evergreen Street Suite 1100 Sacramento, CA 95815 PH: (916) 561-8780 FAX(916) 263-2671 Email:pacommittee@mbc.ca.gov	PA/PAC	**www.pac.ca.gov** **Direct Link To Enforcement Actions:** **www.pac.ca.gov/forms_pubs/disciplinaryactions.shtml**	▪ Link to Consumers ▪ Link to Disciplinary Action ▪ Link to Month within the year at bottom of the page Practitioners listed via month, then Alpha Last report listed December 2016	Monthly Note Reports for December 2014 – July 2015 were all posted at the same time, between 8/25/15 and 8/31/15.
Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834 bopmail@dca.ca.gov Office Main Line (916)-574-7720 **Toll Free Number: 1-866-503-3221.**	PhD, PsyD	**www.psychboard.ca.gov** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/psychboard/subscribe.php**	**Monthly reports are no longer available on the website. (change took place around September or October 2014)** You must sign up for Subscriber list to obtain Enforcement Actions. E-mail will be sent to you. If you don't sign up as a subscriber, the News Letters will provide disciplinary actions. To order copies documents, send your written request, including the name and license number of the licensee, to the attention of the Enforcement Program at the Board's offices in Sacramento. A fee is charged for these documents.	**Via Subscriptions Only** Information must be obtained via subscription. For Subscribers: E-mail

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
CA Board of Registered Nursing 1747 North Market Blvd, Suite 150 Sacramento, CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 Phone: (916) 322-3350 FAX (916) 574-7693. Email: enforcement_brn@dca.ca.gov	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse (CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)	**www.rn.ca.gov** **Unlicensed Practice/Nurse Imposter Citations:** **http://www.rn.ca.gov/enforcement/unlicprac.shtml**	Disciplinary action and license reinstatement information may be obtained by checking the Board's online license verification system. Photocopies of this information may be requested by faxing the Board's Enforcement Program at (916) 574-7693. Or You can subscribe to the National Council of State Board of Nursing (BCSBN) Nursys e-Notify system**.** **See website information below.**	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
National Council of State Board of Nursing (BCSBN) 111 East Wacker Drive, Suite 2900 Chicago, IL 60601-4277 Phone:(312) 525-3600 Fax: **(**312) 279-1032 Email: info@ncsbn.org .	Additional information for RN/LVN/NP/CNM	**www.nursys.com** To subscribe for daily, weekly or monthly (depending on how often you want to be updated) updates on license status, expirations and disciplinary actions. **https://www.nursys.com/EN/ENDefault.aspx**	Nursys e-Notify informs you if you employed RNs or LPN/VNs and Advance Practice Nurses (APRN in the categories of Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM) and Clinical Nurse Specialist (CNS) have received public discipline or alerts from their licensing jurisdiction(s).	.
Speech-Language Pathology & Audiology Board 2005 Evergreen Street, Suite 2100 Sacramento, CA 95815 Email: speechandhearing@dca.ca.gov Main Phone Line: (916) 263-2666 Main Fax Line: (916) 263-2668	SP, AU	**http://www.speechandhearing.ca.gov/** **Direct Link to Accusations Pending and Disciplinary Actions:** **http://www.speechandhearing.ca.gov/consumers/enforcement.shtml** As of1/18/2017the information represents disciplinary action taken by the Board from:7/1/07 – 09/30/2016.	▪ Link to Consumer ▪ Link to Enforcement ▪ Link to Accusations pending or Disciplinary Actions 1. For actions pending Board decisions select "SP/AU" For Speech-Language Pathology & Audiology 2. For Board decisions select "Disciplinary Actions". Last report listed FY 2016-2017 Action Taken	**Quarterly** Disciplinary Actions are listed by fiscal year. Pending Actions are listed alphabetically by first name.

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Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments	Report Frequency
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare /Medicaidsanction &exclusions	**www.oig.hhs.gov** **Direct Link for individuals:** **http://exclusions.oig.hhs.gov/** **Direct Link to exclusion database** **http://oig.hhs.gov/exclusions/exclusions_list.asp**	▪ Link to Exclusions ▪ Link to LEIE Downloadable Databases under the Exclusion Program tab ▪ Link to the various reports, exclusions, reinstatements or databases. To subscribe for notifications follow instructions: Get Email updates	**Monthly** (see note under instructions regarding subscribing notifications)
Noridian Healthcare Solutions **Medicare Opt-Out Physicians** **JE MAC** **1855-609-9960 Select Provider Enrollment** **https://med.noridianmedicare.com/web/jeb**	Medicare Opt-Out	**https://www.noridianmedicare.com** Link to JE Part B **https://med.noridianmedicare.com/web/jeb** **Direct Link to Opt-Out Reports:** **https://med.noridianmedicare.com/web/jeb/enrollment/opt-out/opt-out-listing**	Under Medicare Contracts: ▪ Jurisdiction E Part B ▪ Link to Enrollment ▪ Opt Out of Medicare ▪ Opt Out Listing ▪ Link to Opt Out Listing by State: • Excel Listing or • HTML Listing On 01/20/17 Listing as follows: Excel Listing or (Last update 01/19/17) HTML Listing (Last update 01/19/17) However the HTML update noted the incorrect year 1/19/2016. Correction was made on 2/3/2017	**Quarterly** Last update: 01/19/17(updated 1/20/17) 08/15/16 06/13/16 (6/10/16) 12/23/15 10/30/15 Northern 10/08/15 Southern 08/14/15 07/07/15 04/13/15 03/11/15 01/28/15
CMS.gov **Centers for Medicare & Medicaid Services**	Medicare Opt-Out Affidavits	**https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z**	This link will provide information regarding Opt Out Affidavits and Opt Providers from Data.CMS.gov.	

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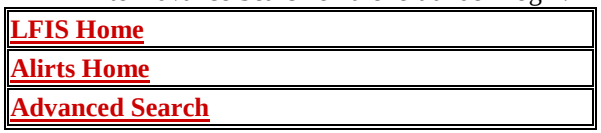
Ongoing Monitoring Website Information 01-25-2017

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments	Report Frequency
Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	**www.medi-cal.ca.gov** **DirectLink to Suspended and Ineligible Provider List**: **http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp**	From Home Page: ▪ Link to References ▪ Suspended and Ineligible Provider List ▪ Under Download the S&I List is the list for the month. (Bottom of the page) Or ▪ Link to References ▪ Provider Enrollment ▪ Suspended and Ineligible Provider List ▪ Under Download the S&I List is the list for the month. (Bottom of the page) Last published 1/13/17	**Monthly**
SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	**https://www.sam.gov/portal/SAM/#1** SAM Registration **https://uscontractorregistration.com/** Note: The SAM website has a user guide: Link to SAM User Guide- v1.8.3 of 350:	Select Search Records at the top ▪ Under: Advanced Search ▪ Select Advance Search - Exclusion ▪ Select Single Search ▪ Scroll down and enter the Active Date to and from for the month you are reviewing ▪ Click search ▪ Export Results	**Monthly**
DEA Office of Diversion Control **800-882-9539** **deadiversionwebmaster@usdoj.gov**	**DEA Verification**	**www.deadiversion.usdoj.gov/** **Direct Link to Validation Form** **https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp**	On the right side under Links: Link to Registration Validation Need DEA #, Name as it appears on your registration and SSN or TIN provided on application. **Note**: Please does not use the Duplicate Certification Link as it is for Physicians, use the Registration Validation Link.	**NA**

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
The Licensed Facility Information system (LFIS) The Automated Licensing Information and Report Tracking System (ALIRTS) Contains license and utilization data information of healthcare facilities in California. The Licensed Facility Information system (LFIS) is maintained by the Office of Statewide Health Planning and Development to collect and display licensing and other basic information about California's hospitals, long-term care facilities, primary care and specialty clinics, home health agencies and hospices.	**Organizational Providers License Verification:** Hospitals Long-term care facilities Home Health Agencies Hospices Primary care and Specialty clinics	**www.alirts.oshpd.ca.gov/Default.aspx** **Direct Link:** **www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx**	The main source of the information in LFIS is the licenses issued by the Department of Health Services (DHS) Licensing and Certification District Offices. Contact information for these District Offices is available at: www.dhs.ca.gov/LNC/default.htm **To search for a facility** • Enter name in box that is found in top right corner  or • Link to Advance Search on the left under Login.  You may search by using the following four search categories, Facility Name, Facility Number, License and Legal Entity. Enter your search parameters within the one category you selected and click the Search button to the right.
The California Department of Public Health (CDPH) General Information (916) 558-1784	**Organizational Providers License Verification:** Hospitals Surgery Centers Home Health Agencies Hospices Dialysis Centers Others	http://www.cdph.ca.gov/Pages/DEFAULT.aspx Licensed Facility Report http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing Health Facilities Search http://hfcis.cdph.ca.gov/search.aspx	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 800-465-3203 customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an**Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

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Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only authorized official distributor of the Death Master file on the web. Final Rule Establishing Certification Program for Access to Death Master File in Effect The National Technical Information Service (NTIS) established a certification program for subscribers to the Limited Access Death Master File (LADMF) through a Final Rule (FR), pursuant to Section 203 of the Bipartisan Budget Act of 2013 (Pub. L. 113-67) which also requires NTIS to recoup the cost of the certification program through processing fees. The FR was published in the Federal Register Wednesday, June 1, 2016, and became effective Monday, November 28, 2016. The FR may be reviewed at **https://www.gpo.gov/fdsys/pkg/FR-2016-06-01/html/2016-12479.htm**.	**Subscription to the Limited Access Death Master File (LADMF)**	**Social Security Death Master File (DMF) Website** https://www.ssdmf.com/FolderID/1/SessionID/%7B17B93F37-71E0-433B-B3F2-B9BA03D721A6%7D/PageVars/Library/InfoManage/Guide.htm **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	You must register to obtain information and there are several fees associated with the service.

Additional Websites

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses **- American Academy of Nurse Practitioners Certification Board (AANPCB) (1/2017)** **(Formerly the American Academy of Nurse Practitioners Certification Program (AANPCP)** **- American Nurses Credentialing Center** (ANCC) **- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties**(ncc) **- Pediatric Nursing Certification Board** (PNCB) **- American Association of Critical-Care Nurses** (AACN)	NP	AANPCB - www.aanpcert.org/ ANCC -**www.nursecredentialing.org** ncc - **www.nccwebsite.org** PNCB - **www.pncb.org** AACN -**www.aacn.org**	Informational only to verify board certification	**Board Certification**
National Commission on Certification of PA's (NCCPA)	PAC	**http://www.nccpa.net/**	Informational only to verify board certification	**Board Certification**
American Midwifery Certification Board (amcb) 849 International Drive, Suite 120 Linthicum, MD 21090 Phone 410-694-9424	CNM and CM	**http://www.amcbmidwife.org/**	Under the Verify AMCB Certification ▪ Click Search button ▪ Enter last Name, First Name and Certification Number ▪ Click Search Button	**Board Certification** Informational only to verify board certification needed

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Additional Websites

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill, NC 27516 Phone 919-537-8031 email: office@abpp.org	PhD, PsyD	**http://www.abpp.org/**	Under Find a Board Certified Psychologists ▪ Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed
Three specialty certifying boards are currently approved under California law for DPMs: – **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA)). – **The American Board of Podiatric Medicine**(Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine – **American Board of Multiple Specialties in Podiatry.** (Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	• American Board of Foot and Ankle Surgery. https://www.abfas.org/ • The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ • American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**

Policy #:	GG.1651Δ
Title:	**Credentialing and Recredentialing of Healthcare Delivery Organizations**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/17
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy evaluates and determines whether to approve or decline Healthcare Delivery Organizations (HDOs) participation in CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines by which CalOptima shall evaluate and select HDOs to participate in CalOptima, in accordance with Title 42, Code of Federal Regulations, Section 422.204 and other applicable laws, regulations, and guidance.

B. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Health Network shall establish policies and procedures to evaluate and approve HDOs to participate in CalOptima programs that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO), or his or her physician Designee, shall have direct responsibility over and actively participate in the Credentialing program.

D. The CalOptima Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an HDO's Credentialing information and determining such HDO's participation in CalOptima.

E. Prior to contracting with an HDO, CalOptima shall require that the HDO be successfully credentialed, as applicable, including confirming that the HDO is in good standing with state and federal regulatory agencies.

F. CalOptima shall categorize HDOs into three (3) risk levels: limited, moderate, and high, for committing Fraud, Waste and Abuse, and will screen HDOs for the appropriate risk level in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 16-012: Provider Credentialing and Recredentialing, Title 42, CFR, Section 455, and as described Section III.A. of this Policy.

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G. CalOptima shall Recredential an HDO at least every three (3) years, utilizing a thirty-six (36)-month cycle to the month, not to the day.

H. On a monthly basis, CalOptima shall monitor the Medicare and Medi-Cal Sanction Lists, which include OIG, SAM, and Medi-Cal. CalOptima shall immediately suspend any HDO identified on the Sanction Lists in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Activities.

I. If CalOptima declines to include an HDO in the CalOptima network, CalOptima shall notify, in writing, such HDO within sixty (60) calendar days of the reason for its decision. An HDO shall have the right to file a complaint about the decision in accordance with CalOptima Policies HH.1101: CalOptima Provider Compliant and MA.9006: Provider Complaint Process, as applicable.

J. CalOptima shall monitor and prevent discriminatory Credentialing decisions as follows:

1. Periodic audits of Credentialing files (in-process, denied, and approved files) to ensure providers are not discriminated against;

2. Periodic audits of HDO complaints to determine if there are complaints alleging discrimination, including a review by the CPRC of quarterly reports of complaints, including discrimination;

3. Maintaining a heterogeneous Credentialing committee membership; and

4. Requiring that those responsible for Credentialing and Recredentialing decisions sign a statement affirming that they do not discriminate when making decisions.

K. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

L. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.

III. PROCEDURE

A. HDO Initial Credentialing

1. Prior to contracting with a Medical HDO, CalOptima shall initiate the Credentialing process and confirm that the Medical HDO is in good standing with state and federal regulatory agencies.

2. The HDO shall submit a signed and dated application and include the following attachments:

a. A current, valid license to operate in California, and confirmation that the HDO is in compliance with any other applicable state or federal requirement, and/or business license (or business tax certificate), as applicable;

b. Accreditation certificate, as applicable. Accrediting bodies include, but are not limited to:

i. Joint Commission: A copy of the certificate of accreditation by the Joint Commission, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization;

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ii. Accreditation Association for Ambulatory Health Care (AAAHC);

iii. Commission on Accreditation of Rehabilitation Facilities (CARF);

iv. Community Health Accreditation Program (CHAP);

v. Continuing Care Accreditation Commission (CCAC); and

vi. Clinical Laboratory Improvement Amendments (CLIA).

c. If an HDO is not accredited, the HDO may submit evidence of an onsite quality review by the state, CMS, or similar agency, or CalOptima must provide evidence of onsite quality review. The onsite quality review must include the criteria used for the assessment, and the process for ensuring that the providers Credential their Practitioners.

d. Certificate of current liability insurance of at least the minimum amounts required by the Contract for Health Care Services, as follows:

i. General/Professional liability at one million ($1,000,000) per occurrence and three million ($3,000,000) aggregate; and

ii. Non-facilities liability at one million ($1,000,000) per occurrence and two million ($2,000,000) aggregate;

e. A copy of any history of sanctions or suspensions from Medicare and/or Medi-Cal; providers terminated from either Medicare or Medi-Cal or on the Suspended and Ineligible Provider list, as applicable.

f. Active enrollment in Medi-Cal and Medicare and a copy of exemptions if applicable;

g. A copy of the organization's Quality Programs, if applicable;

h. Staff roster and copy of all staff certifications, or licensure, if applicable;

i. A valid National Provider Identifier (NPI) number; and

j. A current W-9.

3. CalOptima shall conduct and communicate the results of a Facility Site Review (FSR) for Community Clinics and Free Standing Urgent Care centers providing services to CalOptima Members pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews to incorporate the documents to support review prior to Credentialing decisions.

4. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

5. HDO Screening

a. If CalOptima identifies an HDO as moderate or high-risk, CalOptima will conduct a pre-enrollment site visit prior to contracting.

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b. If CalOptima identifies an HDO as high-risk, CalOptima shall also require verification of a completed criminal background check and fingerprinting for prospective (newly credentialed) home health agencies and suppliers of Durable Medical Equipment and prosthetic and orthotic supplies and any individual with a five percent (5%), or greater, ownership.

B. HDO Recredentialing

1. CalOptima shall Recredential a Medical or Service HDO at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima shall:

   a. Collect and verify, at a minimum, all of the information required for initial credentialing, as set forth in Section III.A. of this Policy; and

   b. Incorporate the following data in the decision-making process:

      i. Quality review activities, including but not limited to, information from:

         a) DHCS, CMS, or other agency, as applicable;

         b) CalOptima quality review results, as applicable;

         c) Review of FSR results, as applicable; and

         d) Review of Grievance, Appeal, and potential quality issue (PQI) case reviews.

      ii. Review of the HDO's compliance with the terms of its contract with CalOptima.

      iii. Member satisfaction, if applicable;

      iv. Medical Record Reviews, if applicable;

      v. FSR results and Physical Accessibility Review Survey (PARS) results, if applicable; and

      vi. Compliance with the terms of the Provider's contract.

2. CalOptima shall ensure that an HDO has current California licensure, accreditation (if applicable), and insurance at all times during such HDO's participation in CalOptima.

3. If CalOptima terminates an HDO during the Recredentialing process for administrative reasons (e.g., the HDO failed to provide complete credentialing information) and not for quality reasons, it may reinstate the HDO within thirty (30) calendar days of termination and is not required to perform initial credentialing. However, CalOptima must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima must perform initial Credentialing of such HDO.

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4. All Recredentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

C. HDO Rights

1. CalOptima shall maintain Credentialing files that include documentation of required elements, as described in this Policy.

2. An HDO shall have the right to file a complaint about the decision in accordance with CalOptima Policies HH.1101: CalOptima Provider Compliant and MA.9006: Provider Complaint Process, as applicable.

D. Credentialing Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Completed Credentialing and Recredentialing files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the HDO within the last seven (7) years from the date of the Credentialing or Recredentialing review

i. A clean file shall be considered approved and effective on the date that the CMO, or his or her physician Designee, review and approve a HDO's Credentialing or Recredentialing file, and deem the file clean.

ii. Approved, clean file lists shall be presented at the CPRC and reflected in the meeting minutes.

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the HDO, or files of HDOs that have a history of being included on the Medi-Cal Suspended and Ineligible Provider List.

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the Provider submits all the required information.

ii. CPRC minutes shall reflect thoughtful consideration of information presented in the credentialing file.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

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3. The CPRC shall make recommendations based on the HDO's ability to deliver care based on the Credentialing information collected from the file review process.

    a. The CalOptima Quality Improvement Department shall send the HDO, or applicant, a decision letter, within sixty (60) calendar days of the decision:

        i. Acceptance;

        ii. Approved with Restrictions; or

        iii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

    b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

    c. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any HDO, during the HDO's Credentialing, or Recredentialing process, the application shall be considered expired.

4. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Credentialing data into CalOptima's core business system, which updates pertinent information into the online Provider directory.

IV. ATTACHMENTS

A. Ongoing Monitoring Website Information Matrix

V. REFERENCES

A. 2017 NCQA Standards and Guidelines
B. California Evidence Code, §1157
C. CalOptima Contract for Health Care Services
D. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima PACE Program Agreement
G. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
H. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
I. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
J. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
K. CalOptima Policy HH.1101: CalOptima Provider Compliant
L. CalOptima Policy MA.9006: Provider Complaint Process
M. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
A. Department of Health Care Services All Plan Letter (APL) 16-012: Provider Credentialing and Recredentialing

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N. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 424, 431 and 455.450
O. Title 45, Code of Federal Regulations, §455
P. Title 42, United States Code, §1320a-7(a)
Q. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 06/01/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/01/2017	GG.1651Δ	Credentialing and Recredentialing	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.
Appeal	A request by the Member or the Member's Authorized Representative for review of any decision to deny, modify, or discontinue a Covered Service.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a provider to provide quality and safe patient care services.
Credentialing Peer Review Committee	Peer review body who reviews provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Facility Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a site to support the delivery of quality health care services using the Facility Site Review (FSR), Medical Record Review (MRR) or Physical Accessibility Review Survey (PARS), DHCS provided tools.
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. § 1347).
Grievance	An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group, physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Health Delivery Organizations (HDOs)	Organizations that are contracted to provide medical services such as hospitals, home health agencies, skilled nursing facilities, free standing surgical centers, extended care facilities (LTC), nursing homes (assisted living), hospice, community clinic, urgent care centers, dialysis centers, Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, rehabilitation facilities.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An enrollee-beneficiary of a CalOptima program.

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Term	Definition
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers
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	Any person or institution that furnishes Covered Services.
Recredentialing	The process by which provider qualifications or status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Service Health Delivery Organizations (HDOs)	Organizations that are contracted to provide services that support Member needs such as ambulance, non-emergency medical transportation (NEMT) providers, and providers of other Member-facing services such as, other transportation, meal, and homecare services.
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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Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 PH:(916) 263-2382 or (800) 633-2322 Enforcement Central File Room PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord. (916) 263-2449	MD	**www.mbc.ca.gov** **All communications for disciplinary actions will be done by e-mail to subscribers.** **Link to subscribe for actions:** **http://www.mbc.ca.gov/Subscribers/** **Link for all Disciplinary Actions/License Alerts distributed:** **http://www.mbc.ca.gov/Publications/Disciplinary_Actions/** **Enforcement Public Document Search (Search by Name or Lic:** **http://www2.mbc.ca.gov/PDL/Search.aspx**	You must signup to subscribe for E-mail notifications of accusations, license suspensions, restrictions, revocations, or surrenders for physicians and surgeons licensed by the MBOC. Disciplinary action documents are obtainable via the web-site by: • Link to Enforcement Public Document Search (on the left side of page under check your doctor online) or in the • License verification section; Under Public Documents – Top Right	Bi-Monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final
Osteopathic Medical Board of CA 1300 National Drive, Suite #150 Sacramento, CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax E-mail:osteopathic@dca.ca.gov Enforcement/Disciplines(916)-928-8390 Ext. 6	DO	**www.ombc.ca.gov** **Direct Link To Enforcement Actions:** **http://www.ombc.ca.gov/consumers/enforce_action.shtml** **Subscribe to e-mail Alerts** **http://www.ombc.ca.gov/consumers/enforce_action.shtml**	▪ Link to Consumers Tab at the top ▪ Link to Enforcement Action Can get on a distribution list by e-mailing J. Corey Sparks, Lead Enforcement Analyst E-mail: Corey.Sparks@dca.ca.gov 916-928-8393 (PH) 916-928-8392 (FAX) The board is behind in updating the website. You can subscribe or send an e-mail to get on the distribution list. 01/18/17 – 2nd Quarter 2016 is the last posted report. E-mails distribution is current	Quarterly via the Website E-Mail Distribution list:

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Medical Board of California **Board of Podiatric Medicine** 2005 Evergreen Street, Ste. 1300 Sacramento, CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651 Email: BPM@dca.ca.gov Enforcement Program Central File Room Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 FAX: (916) 263-2420	DPM	**www.bpm.ca.gov** **Direct Link toEnforcement Resources:** **http://www.bpm.ca.gov/consumers/index.shtml** **Subscribers list** **http://www.mbc.ca.gov/Subscribers/** .	▪ Consumers ▪ Link to Enforcement Resources ▪ Link to Recent Disciplinary Actions(Categorized by the following): ➢ Decisions ➢ Accusations Filed ➢ Accusation and Petition to Revoke Probation filed ➢ Accusations and/or Statement of Issues Withdrawn or Dismissed ➢ Statement of Issues Listed alphabetically by category: Decision, Accusation, etc. 9/21/16 was the latest update on 12/15/16 and no reports were available. Updated01/17/17	Board of Podiatric Medicine: Changes to viewing information. On the website go to recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. History not available only current accusations and decisions latest one year from effective date. You can subscribe to actions related to licenses
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento, CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204 Email: acupuncture@dca.ca.gov To order copies of actions send to Attn of Consumer Protection Program	LAC/AC	**www.acupuncture.ca.gov** **Direct Link to Disciplinary Actions:** **www.acupuncture.ca.gov/consumers/board_actions.shtml** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/acupuncture/subscribe.php**	▪ Link to Consumer at the top ▪ Link to DisciplinaryActions Last update January 5, 2017	Monthly running report listed Alpha Newer actions highlighted with date in blue. Note: Board meetings are held quarterly.

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

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Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625 E-Mail: BBSWebmaster@bbs.ca.gov	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	**www.bbs.ca.gov** **Sign up for subscribers list for disciplinary actions.** **https://www.dca.ca.gov/webapps/bbs/subscribe.php**	You must sign up for Subscriber list to obtain Enforcement Actions. E-mail will be sent to you. If you don't sign up as a subscriber, the News Letters will provide disciplinary actions.	**Via Subscriptions Only** Information must be obtained via subscription. For Subscribers: E-mail reports were sent:
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street, Suite 142A Sacramento, CA 95814 PH (916) 263-5355 FAX (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	**www.chiro.ca.gov** **Monthly Reports** **http://www.chiro.ca.gov/enforcement/actions.shtml**	Note monthly disciplinary actions reports ▪ Link to Enforcement at the top right side (next to Contact Us) ▪ Link to Disciplinary Actions ▪ Actions listed by month and year Last report December 2016	Monthly
Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 PH: (916) 263-2300 PH: (877)729-7789 Toll Free Fax #: (916) 263-2140 Email:dentalboard@dca.ca.gov Enforcement Unit PH: 916-274-6326	DDS, DMD	**www.dbc.ca.gov** **Direct Link to Disciplinary Actions:** **http://www.dbc.ca.gov/consumers/hotsheets.shtml**	▪ Link Home Page ▪ Under Highlights at the bottom of the page-Link to Hot Sheet! Dental Disciplinary Action ▪ Actions listed by month and year Or ▪ Link to Consumer ▪ Hot Sheets (Summary of Administrative Actions Last report December 2016	Monthly Note: At the end of the list it provides a date posted. As of 12/31/2016

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Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento, CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701 Email: cbot@dca.ca.gov Email: EnfPrg@dca.ca.gov	OT, OTA	**www.bot.ca.gov** **Direct Link To Enforcement Actions:** **http://www.bot.ca.gov/consumers/disciplinary_action.shtml** **Sign up for subscribers list for disciplinary actions: https://www.dca.ca.gov/webapps/bot/subscribe.php**	▪ Link to Consumer at the top ▪ Link to Disciplinary Action Practitioners are listed under: Revocations, Surrenders and Other Disciplinary Orders: A – L and M – Z. **Sign up to receive a monthly Hot Sheet List of disciplinary actions via e-mail to:** EnfPrg.Enfprg@dca.ca.gov Will need to send a written request to obtain the information, which may be sent back to you via e-mail.	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action. E-Mail Submission
California State Board of Optometry 2450 Del Paso Road, Suite 105 Sacramento, CA 95834 PH:(916) 575-7170 Fax (916) 575-7292 Email: optometry@dca.ca.gov	OD	**www.optometry.ca.gov** **Direct Link To Enforcement Actions:** **http://www.optometry.ca.gov/consumers/disciplinary.shtml**	▪ Link to Consumer at the top ▪ Link to Citations and Disciplinary Actions ▪ Bottom of page actions are posted by year Practitioners are listed by year, type of action and then alphabetically Note: Report provides a Last Updated date at the top of the report. Last update12/22/2016	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. Recommend monthly review. The Board typically adopts formal disciplinary actions during regularly scheduled quarterly meetings.

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento, CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	**www.ptb.ca.gov** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/ptbc/interested_parties.php**	Disciplinary action and license reinstatement information may be obtained by checking the Board's online license verification system. Last update 9/28/15	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
Physician AssistantBoard (PAB) 2005 Evergreen Street Suite 1100 Sacramento, CA 95815 PH: (916) 561-8780 FAX(916) 263-2671 Email:pacommittee@mbc.ca.gov	PA/PAC	**www.pac.ca.gov** **Direct Link To Enforcement Actions:** **www.pac.ca.gov/forms_pubs/disciplinaryactions.shtml**	▪ Link to Consumers ▪ Link to Disciplinary Action ▪ Link to Month within the year at bottom of the page Practitioners listed via month, then Alpha Last report listed December 2016	Monthly Note Reports for December 2014 – July 2015 were all posted at the same time, between 8/25/15 and 8/31/15.
Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834 bopmail@dca.ca.gov Office Main Line (916)-574-7720 **Toll Free Number: 1-866-503-3221.**	PhD, PsyD	**www.psychboard.ca.gov** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/psychboard/subscribe.php**	**Monthly reports are no longer available on the website. (change took place around September or October 2014)** You must sign up for Subscriber list to obtain Enforcement Actions. E-mail will be sent to you. If you don't sign up as a subscriber, the News Letters will provide disciplinary actions. To order copies documents, send your written request, including the name and license number of the licensee, to the attention of the Enforcement Program at the Board's offices in Sacramento. A fee is charged for these documents.	**Via Subscriptions Only** Information must be obtained via subscription. For Subscribers: E-mail

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
CA Board of Registered Nursing 1747 North Market Blvd, Suite 150 Sacramento, CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 Phone: (916) 322-3350 FAX (916) 574-7693. Email: enforcement_brn@dca.ca.gov	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse (CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)	**www.rn.ca.gov** **Unlicensed Practice/Nurse Imposter Citations:** **http://www.rn.ca.gov/enforcement/unlicprac.shtml**	Disciplinary action and license reinstatement information may be obtained by checking the Board's online license verification system. Photocopies of this information may be requested by faxing the Board's Enforcement Program at (916) 574-7693. Or You can subscribe to the National Council of State Board of Nursing (BCSBN) Nursys e-Notify system**.** **See website information below.**	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
National Council of State Board of Nursing (BCSBN) 111 East Wacker Drive, Suite 2900 Chicago, IL 60601-4277 Phone:(312) 525-3600 Fax: **(**312) 279-1032 Email: info@ncsbn.org .	Additional information for RN/LVN/NP/CNM	**www.nursys.com** To subscribe for daily, weekly or monthly (depending on how often you want to be updated) updates on license status, expirations and disciplinary actions. **https://www.nursys.com/EN/ENDefault.aspx**	Nursys e-Notify informs you if you employed RNs or LPN/VNs and Advance Practice Nurses (APRN in the categories of Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM) and Clinical Nurse Specialist (CNS) have received public discipline or alerts from their licensing jurisdiction(s).	.
Speech-Language Pathology & Audiology Board 2005 Evergreen Street, Suite 2100 Sacramento, CA 95815 Email: speechandhearing@dca.ca.gov Main Phone Line: (916) 263-2666 Main Fax Line: (916) 263-2668	SP, AU	**http://www.speechandhearing.ca.gov/** **Direct Link to Accusations Pending and Disciplinary Actions:** **http://www.speechandhearing.ca.gov/consumers/enforcement.shtml** As of1/18/2017the information represents disciplinary action taken by the Board from:7/1/07 – 09/30/2016.	▪ Link to Consumer ▪ Link to Enforcement ▪ Link to Accusations pending or Disciplinary Actions 1. For actions pending Board decisions select "SP/AU" For Speech-Language Pathology & Audiology 2. For Board decisions select "Disciplinary Actions". Last report listed FY 2016-2017 Action Taken	**Quarterly** Disciplinary Actions are listed by fiscal year. Pending Actions are listed alphabetically by first name.

Ongoing Monitoring Website Information 01-25-2017

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments	Report Frequency
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare /Medicaidsanction &exclusions	**www.oig.hhs.gov** **Direct Link for individuals:** **http://exclusions.oig.hhs.gov/** **Direct Link to exclusion database** **http://oig.hhs.gov/exclusions/exclusions_list.asp**	▪ Link to Exclusions ▪ Link to LEIE Downloadable Databases under the Exclusion Program tab ▪ Link to the various reports, exclusions, reinstatements or databases. To subscribe for notifications follow instructions: Get Email updates	**Monthly** (see note under instructions regarding subscribing notifications)
Noridian Healthcare Solutions **Medicare Opt-Out Physicians** **JE MAC** **1855-609-9960 Select Provider Enrollment** **https://med.noridianmedicare.com/web/jeb**	Medicare Opt-Out	**https://www.noridianmedicare.com** Link to JE Part B **https://med.noridianmedicare.com/web/jeb** **Direct Link to Opt-Out Reports:** **https://med.noridianmedicare.com/web/jeb/enrollment/opt-out/opt-out-listing**	Under Medicare Contracts: ▪ Jurisdiction E Part B ▪ Link to Enrollment ▪ Opt Out of Medicare ▪ Opt Out Listing ▪ Link to Opt Out Listing by State: • Excel Listing or • HTML Listing On 01/20/17 Listing as follows: Excel Listing or (Last update 01/19/17) HTML Listing (Last update 01/19/17) However the HTML update noted the incorrect year 1/19/2016. Correction was made on 2/3/2017	**Quarterly** Last update: 01/19/17(updated 1/20/17) 08/15/16 06/13/16 (6/10/16) 12/23/15 10/30/15 Northern 10/08/15 Southern 08/14/15 07/07/15 04/13/15 03/11/15 01/28/15
CMS.gov **Centers for Medicare & Medicaid Services**	Medicare Opt-Out Affidavits	**https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z**	This link will provide information regarding Opt Out Affidavits and Opt Providers from Data.CMS.gov.	

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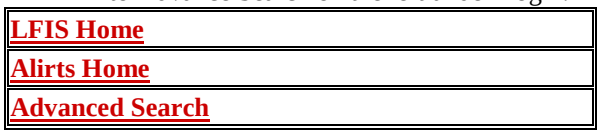
Ongoing Monitoring Website Information 01-25-2017

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments	Report Frequency
Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	**www.medi-cal.ca.gov** **DirectLink to Suspended and Ineligible Provider List**: **http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp**	From Home Page: ▪ Link to References ▪ Suspended and Ineligible Provider List ▪ Under Download the S&I List is the list for the month. (Bottom of the page) Or ▪ Link to References ▪ Provider Enrollment ▪ Suspended and Ineligible Provider List ▪ Under Download the S&I List is the list for the month. (Bottom of the page) Last published 1/13/17	**Monthly**
SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	**https://www.sam.gov/portal/SAM/#1** SAM Registration **https://uscontractorregistration.com/** Note: The SAM website has a user guide: Link to SAM User Guide- v1.8.3 of 350:	Select Search Records at the top ▪ Under: Advanced Search ▪ Select Advance Search - Exclusion ▪ Select Single Search ▪ Scroll down and enter the Active Date to and from for the month you are reviewing ▪ Click search ▪ Export Results	**Monthly**
DEA Office of Diversion Control **800-882-9539** **deadiversionwebmaster@usdoj.gov**	**DEA Verification**	**www.deadiversion.usdoj.gov/** **Direct Link to Validation Form** **https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp**	On the right side under Links: Link to Registration Validation Need DEA #, Name as it appears on your registration and SSN or TIN provided on application. **Note**: Please does not use the Duplicate Certification Link as it is for Physicians, use the Registration Validation Link.	**NA**

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
The Licensed Facility Information system (LFIS) The Automated Licensing Information and Report Tracking System (ALIRTS) Contains license and utilization data information of healthcare facilities in California. The Licensed Facility Information system (LFIS) is maintained by the Office of Statewide Health Planning and Development to collect and display licensing and other basic information about California's hospitals, long-term care facilities, primary care and specialty clinics, home health agencies and hospices.	**Organizational Providers License Verification:** Hospitals Long-term care facilities Home Health Agencies Hospices Primary care and Specialty clinics	**www.alirts.oshpd.ca.gov/Default.aspx** **Direct Link:** **www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx**	The main source of the information in LFIS is the licenses issued by the Department of Health Services (DHS) Licensing and Certification District Offices. Contact information for these District Offices is available at: www.dhs.ca.gov/LNC/default.htm **To search for a facility** • Enter name in box that is found in top right corner  or • Link to Advance Search on the left under Login.  You may search by using the following four search categories, Facility Name, Facility Number, License and Legal Entity. Enter your search parameters within the one category you selected and click the Search button to the right.
The California Department of Public Health (CDPH) General Information (916) 558-1784	**Organizational Providers License Verification:** Hospitals Surgery Centers Home Health Agencies Hospices Dialysis Centers Others	http://www.cdph.ca.gov/Pages/DEFAULT.aspx Licensed Facility Report http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing Health Facilities Search http://hfcis.cdph.ca.gov/search.aspx	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 800-465-3203 customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an**Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

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Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only authorized official distributor of the Death Master file on the web. Final Rule Establishing Certification Program for Access to Death Master File in Effect The National Technical Information Service (NTIS) established a certification program for subscribers to the Limited Access Death Master File (LADMF) through a Final Rule (FR), pursuant to Section 203 of the Bipartisan Budget Act of 2013 (Pub. L. 113-67) which also requires NTIS to recoup the cost of the certification program through processing fees. The FR was published in the Federal Register Wednesday, June 1, 2016, and became effective Monday, November 28, 2016. The FR may be reviewed at **https://www.gpo.gov/fdsys/pkg/FR-2016-06-01/html/2016-12479.htm**.	**Subscription to the Limited Access Death Master File (LADMF)**	**Social Security Death Master File (DMF) Website** https://www.ssdmf.com/FolderID/1/SessionID/%7B17B93F37-71E0-433B-B3F2-B9BA03D721A6%7D/PageVars/Library/InfoManage/Guide.htm **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	You must register to obtain information and there are several fees associated with the service.

Additional Websites

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses **- American Academy of Nurse Practitioners Certification Board (AANPCB) (1/2017)** **(Formerly the American Academy of Nurse Practitioners Certification Program (AANPCP)** **- American Nurses Credentialing Center** (ANCC) **- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties**(ncc) **- Pediatric Nursing Certification Board** (PNCB) **- American Association of Critical-Care Nurses** (AACN)	NP	AANPCB - www.aanpcert.org/ ANCC -**www.nursecredentialing.org** ncc - **www.nccwebsite.org** PNCB - **www.pncb.org** AACN -**www.aacn.org**	Informational only to verify board certification	**Board Certification**
National Commission on Certification of PA's (NCCPA)	PAC	**http://www.nccpa.net/**	Informational only to verify board certification	**Board Certification**
American Midwifery Certification Board (amcb) 849 International Drive, Suite 120 Linthicum, MD 21090 Phone 410-694-9424	CNM and CM	**http://www.amcbmidwife.org/**	Under the Verify AMCB Certification ▪ Click Search button ▪ Enter last Name, First Name and Certification Number ▪ Click Search Button	**Board Certification** Informational only to verify board certification needed

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Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill, NC 27516 Phone 919-537-8031 email: office@abpp.org	PhD, PsyD	**http://www.abpp.org/**	Under Find a Board Certified Psychologists ▪ Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed
Three specialty certifying boards are currently approved under California law for DPMs: – **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA)). – **The American Board of Podiatric Medicine**(Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine – **American Board of Multiple Specialties in Podiatry.** (Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	• American Board of Foot and Ankle Surgery. https://www.abfas.org/ • The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ • American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**

Medi-Cal CalOptima A Public Agency Better. Together.

Policy #: GG.1616Δ
Title: **Fair Hearing Plan for Practitioners**
Department: Medical Affairs
Section: Quality Improvement

CEO Approval: Michael Schrader

Effective Date: 4/96
Last Review Date: 06/01/17
Last Revised Date: 06/01/17

~~This policy shall apply to the following CalOptima line of business (LOB)~~Applicable to:

- ~~Medi-Cal~~
- ~~OneCare~~
- OneCare Connect
- PACE

I. PURPOSE

This policy~~o~~ defines the process that CalOptima~~, or a Health Network (HN), or a Physician Medical Group (PMG)~~ shall use to provide a fair ~~review of decisions that affect CalOptima, HN or PMG,~~procedure to Practitioners ~~or applicants,~~when adverse actions are proposed to be taken or are taken by CalOptima and ~~protect peer review participants from liability.~~for which a report is required to be filed under California Business and Professions Code S~~s~~ection 805 of the -and/or with the National Practitioner Data Bank (NPDB).

~~DEFINITIONS~~

II. POLICY

A. CalOptima~~, HN, or PMG~~ shall offer Practitioners ~~and applicants~~ the procedural rights ~~as described~~set forth in this P~~p~~olicy.

B. A Peer Review investigation may be initiated by CalOptima whenever reliable information indicates a Practitioner ~~or applicant~~may have engaged in actions which adversely affect or could adversely affect the health or welfare of a CalOptima Member and may call into question his or her competence or professional conduct.

C. ~~,~~In the event CalOptima believes an adverse action is warranted, as a result of the peer review investigation, CalOptima shall provide written notice to the Practitioner, within thirty (30) calendar days of the decision of the adverse recommendation and the right to request a hearing as provided in this P~~p~~olicy.

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B.D. A Practitioner may request a hearing if CalOptima, HN, or PMG takes or recommends any of the following actions, and if CalOptima, HN, or PMG would be required to file a report pursuant to Section 805 of the California Business and Professions Code and Section 1370 of the California Health and Safety Code, if the appeal body determines that such action is based on medical disciplinary cause or reason:and/or National Practitioner Data Bank requirements based on one (1) or more of the following actions::

1. CalOptima Initiated Actions:

1.a. Denial of an applicant's a Practitioner's application for CalOptima, HN or PMG participation for a medical disciplinary cause or reason;

2.b. Non-renewal of a Practitioner's CalOptima, HN or PMG participation for a medical disciplinary cause or reason;

3.c. Restriction on a Practitioner's CalOptima, HN or PMG participation for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a medical disciplinary cause or reason;

d. Termination of a Practitioner's CalOptima participation for a medical disciplinary cause or reason; and

e. Imposition of summary suspension of a Practitioner's CalOptima participation for a medical disciplinary cause or reason if the summary suspension remains in effect for more than fourteen (14) calendar days.

2. Practitioner-Initiated Actions:

4. Resignation or leave of absence by a Practitioner from CalOptima, HN or PMG participation after receiving: (i) notice of an investigation;

a. Withdrawal or abandonment of an applicant's initiated for a medical disciplinary cause or reason; or (ii) notice that his or her application is denied or will be denied for a medical disciplinary cause or reason;

5.b. Withdrawal or abandonment of a Practitioner's application for CalOptima, HN or PMG participation after: (i) notice of an investigation or the impending denial of an applicationinitiated for a medical disciplinary cause or reason; or (ii) notice that his or her application is denied or will be denied for a medical disciplinary cause or reason;

6.c. Withdrawal or abandonment of a Practitioner's request for renewal of CalOptima, HN or PMG participation; participation after: (i) notice of an investigation initiated for a medical disciplinary cause or reason; or (ii) notice that his or her application is denied or will be denied for a medical disciplinary cause or reason.

7. Summary suspension of a Practitioner from providing Covered Services for more than fourteen (14) consecutive calendar days; and

8. Termination of a Practitioner's CalOptima, HN or PMG participation.

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3. ~~A~~Other Disciplinary Actions

~~C.~~ Any other disciplinary action or recommendation that must be reported to the Medical Board and/or the National Practitioner~~, applicant, or agency whose decision prompted the hearing may Appeal the Judicial Review Committee's decision if:~~

~~1. There was substantial noncompliance with the requirements of fair procedure, which has created demonstrable prejudice;~~

~~2. The decision was arbitrary or capricious, or was not supported by the evidence, based upon the hearing record or such additional information as may be permitted pursuant to the Appeals procedure; or~~

~~3.~~a. ~~A rule or procedure relied on by the Judicial Hearing Committee in arriving at its decision was not reasonable or warranted~~ Data Bank.

~~D.~~E. Except as otherwise provided in this ~~P~~policy, no Practitioner ~~or applicant~~ shall be entitled, as a matter of right, to more than one (1) ~~Judicial Review Committee~~ hearing ~~and one (1) Appeal~~ on any matter ~~that may be the subject of a hearing and Appeal~~.

~~E.~~F. With respect to the entirety of this process, technical, insignificant, or non-prejudicial deviations from the procedures set forth in this process shall not be grounds for invalidating the action taken.

~~F. Exhaustion of internal administrative remedies~~

~~1. A Practitioner~~If adverse action, as described in CalOptima Policy GG.1607Δ: Monitoring Adverse Activities, is taken or ~~applicant~~ recommended, a Practitioner shall exhaust all remedies afforded by this ~~P~~policy before resorting to legal action.

~~2.~~ If a Practitioner ~~or applicant~~ fails to exhaust all remedies afforded by this ~~P~~policy, CalOptima~~, HN or PMG~~ shall deem such Practitioner ~~or applicant~~ to~~:~~

~~a. Waive~~ have waived all hearing and ~~Appeal~~appeal requirements~~;~~ and

~~b.~~G. ~~Accept CalOptima, HN or PMG's~~ to have accepted CalOptima's action or recommendation.

H. This policy does not apply to the imposition of administrative restrictions, suspensions, or terminations resulting from the Practitioner's failure to meet specific credentialing and contractual obligations including, without limitation, the failure to meet Minimum Physician Standards, or where restrictions, suspensions, or terminations are not based on a medical disciplinary cause or reason.

I. The hearing process described in this policy may not be used to challenge any established law, rule, regulation, policy, or requirement and the Judicial Review Committee has no authority to make

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findings or decisions to modify, limit, or overrule any established law, rule, regulation, policy, or requirement and it shall not entertain any such challenge.

J. Unless a summary suspension is imposed, if the Practitioner waives his or her procedural rights, then the recommendation of CalOptima shall be submitted for final action, as provided in Section III~~V~~.A.20~~1~~.f.

K. Health Networks shall have policies and procedures consistent with this policy that provide Practitioners with formal appeal rights when the Health Network takes or proposes adverse action for which a report is required to be filed under Section 805 of the California Business and Professions Code and/or with the NPDB.

III. PROCEDURE

A. Hearing Procedure

1. Notice of Action

a. If CalOptima~~, HN or PMG~~ takes or recommends any of the final actions described in Section ~~II.B~~III.D. of this P~~p~~olicy, CalOptima~~, HN or PMG~~ shall provide written notice as soon as possible after CalOptima takes or recommends the action but not later than thirty (30) calendar days thereafter to the Practitioner ~~or applicant~~ of the action or recommendation, and the Practitioner's ~~or applicant's~~ right to a hearing.

b. ~~CalOptima, HN or PMG's~~The notice shall include:

i. The action or recommendation against the Practitioner ~~or applicant~~;

ii. CalOptima's~~, HN's or PMG's~~ obligation to report such action, if adopted, in accordance with Section 805 of the California Business and Professions Code and/or National Practitioner Data Bank requirements;

iii. A brief ~~indication~~statement of the reasons for the action or recommendation;

~~iv.~~ The Practitioner's ~~or applicant's~~ right to request a hearing~~:~~

~~1) Regardless of whether or not CalOptima, HN or PMG takes or recommends such action based on medical disciplinary cause or reason; and~~

~~2)~~iv. ~~Within~~ within thirty (30) calendar days after the date of the notice~~.~~; and

v. ~~All other hearing rights as described in~~ A copy of this Fair Hearing Plan P~~p~~olicy.

2. Request for Hearing

a. A Practitioner ~~or applicant~~ shall request a hearing by a Judicial Review Committee within thirty (30) calendar days after the date of receipt of the notice described in Section ~~III~~III~~V~~.A.1 of this P~~p~~olicy.

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~~b.~~ The Practitioner ~~or applicant~~ shall request such hearing in writing to the CalOptima~~, HN or PMG~~ Chief Medical Officer (CMO~~).~~

~~c.~~b. ~~The Practitioner has the right to be represented by an attorney or another person of their choice~~), or designee, as applicable.

~~d.~~c. If the Practitioner ~~or applicant~~ fails to request a hearing in accordance with Sections ~~III~~IIIV.A.2.a and ~~III~~IIIV.A.2.b of this policy, CalOptima~~, HN or PMG~~ shall deem such Practitioner ~~or applicant~~ to:

i. ~~Waive~~Have waived the right to a hearing and to any appellate review for which he or she may have been eligible under this policy; and

ii. ~~Accept CalOptima, HN or PMG's~~Have accepted CalOptima's action or ~~recommendation~~final proposed action, which shall thereupon become effective immediately.

3. Hearing Schedule

a. Upon receipt of a Practitioner's ~~or applicant's~~ written request for a hearing, ~~the CMO~~CalOptima shall deliver such request to the ~~agency~~peer review committee whose decision prompted the hearing.

~~b. The agency whose decision prompted the hearing shall schedule and arrange for a hearing within thirty (30) calendar days after receipt of the Practitioner's or applicant's request from the CMO.~~

~~c.~~b. ~~The hearing shall take place~~The hearing shall commence not less than thirty (30) calendar days and not more than sixty (60) calendar days after the date the CMO receives the Practitioner's ~~or applicant's~~ request for a hearing. ~~CalOptima, HN, or PMG may delay the hearing if:~~

i. CalOptima~~, HN,~~ may extend the time for commencement of the hearing, but in the event the request is received from a Practitioner who is under summary suspension, the hearing shall be held as soon as arrangements may be reasonably made, so long as the Practitioner has at least thirty (30) calendar days from the date of the notice to prepare for the hearing or ~~PMG~~provides written waiver of this right;

~~i.~~ii. CalOptima and the Practitioner ~~or applicant~~may agree, in writing, to delay the hearing~~. in writing~~; or

~~ii.~~iii. The ~~Hearing Officer issues~~hearing officer may issue a written decision to delay the hearing on a showing of good cause.

~~4. If CalOptima, HN or PMG summarily suspends, in whole or in part, a Practitioner's participation in CalOptima, HN, or PMG and such Practitioner requests a hearing, CalOptima, HN or PMG shall hold the hearing as soon as arrangement may reasonably be made.~~.

~~5.~~4. Notice of Hearing (Charges)

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a. ~~CalOptima, HN, or PMG~~If the Practitioner makes a request for a hearing on a timely basis, CalOptima shall provide written notice of the hearing to the Practitioner ~~or applicant~~ at least thirty (30) calendar days prior to the date of the hearing.

b. Such notice shall include:

i. The time, date, and location of the hearing;

~~ii. A notice of charges that includes:~~

~~1)~~ The reason(s) for the final proposed action taken or ~~recommendation~~recommended, including acts or omissions with which the Practitioner ~~or applicant~~ is charged~~;~~

~~2) List of charts~~ and a list of the patients whose care is in question, ~~if~~where applicable; ~~and~~

~~3) List of witnesses expected to testify at the hearing on behalf of CalOptima, HN or PMG.~~

~~iii.~~ii. ~~Reason for~~ or, if the action involves denial~~, if the hearing is a result~~ of a ~~denial of an applicant's~~Practitioner's application~~.~~ for participation, the reason(s) for the denial; and

iii. A summary of the Practitioner's rights and the hearing process.

c. CalOptima may amend the Notice of Hearing at any time so long as the Practitioner has reasonable opportunity to prepare for and present a defense to the amended charges.

~~6.~~5. Judicial Review Committee

a. Upon receipt of a request for a hearing, the CalOptima CMO shall appoint a Judicial Review Committee, at least a majority of whom shall be peers of the Practitioner ~~or applicant~~, and shall designate a chairperson. The Judicial Review Committee shall be composed of not less than three (3) members.

b. The chairperson shall hear all pre-hearing matters until the selection of a hearing officer.

c. All members of the Judicial Review Committee shall be present ~~during the entire hearing~~at each hearing session, Judicial Review Committee meeting, and deliberation session unless both parties agree that any one (1) member need not attend a particular session or meeting.

d. The decision of the Judicial Review Committee shall be by a majority vote of the members. The numerical vote shall be recorded.

6. Arbitrator

a. CalOptima may propose that an arbitrator be selected in lieu of a Judicial Review Committee. The use of an arbitrator shall be subject to mutual agreement by CalOptima and

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the Practitioner. If an arbitrator is used, the process described in Section III~~n IV~~.A.6~~7~~.b. of this policy will apply.

b. The arbitrator shall meet the same qualifications as the hearing officer and will be selected using a process mutually acceptable to CalOptima and the Practitioner. If the parties are unable to agree, the arbitrator will be selected pursuant to JAMS Comprehensive Arbitration Rules & Procedures. If an arbitrator is selected, no separate Judicial Review Committee or hearing officer shall be appointed and all references in this P~~p~~olicy to the Judicial Review Committee or hearing officer duties and responsibilities shall be read as applicable to the arbitrator.

7. Hearing Officer

a. The CalOptima CMO shall appoint a hearing officer to preside at the hearing.

i. The hearing officer shall be an attorney at law qualified to preside over a hearing, and preferably shall have experience in medical staff disciplinary matters.

ii. The hearing officer shall:

a) Not be biased for or against the Practitioner ~~or applicant~~;

b) Gain no direct financial benefit from the outcome; and

c) Not act as a prosecuting officer or as an advocate for any party.

b. The hearing officer shall participate in the deliberations, and act as a legal advisor to the Judicial Review Committee, but shall not be entitled to vote.

c. The hearing officer shall ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained.

d. The hearing officer shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing.

e. The hearing officer shall have the authority and discretion, in accordance with this policy, to:

i. Grant continuances;

ii. Determine when attorneys may be permitted;

~~iii. Rule on disputed discovery requests;~~

~~iv. Decide when evidence may or may not be introduced;~~

~~v.~~iii. Rule on challenges to Judicial Review Committee members;

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~~vi.~~iv. Rule on challenges to himself or herself serving as the hearing officer; ~~and~~

~~vii.~~v. Rule on questions raised prior to, or during, the hearing pertaining to matters of law, procedures, or the admissibility of evidence;~~.~~

vi. Exercise discretion in limiting the number of witnesses and the overall amount of evidence introduced at the hearing;

vii. Impose any safeguards for the protection of the Peer Review process and, as justice requires, pursuant to Business and Professions Code Section 809.2;

viii. If requested by the Judicial Review Committee, assist in preparation of the Judicial Review Committee's report and recommendations; and

ix. Take such action as may be warranted by the circumstances if the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner.

8. Failure to Appear

a. A Practitioner's failure to appear and proceed at the hearing, absent good cause, shall be deemed voluntary acceptance of the recommendation or action. In such cases, the matter will be forwarded for final action as provided in Section III~~V~~.A.20~~1~~.f of this P~~p~~olicy.

9. Postponements and Extensions

a. Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted under this policy may be allowed by the hearing officer on a showing of good cause or upon agreement of parties.

b. Extensions of time necessary to appoint a Judicial Review Committee, hearing officer, and/or arbitrator shall be deemed good cause as long as both parties proceed in good faith.

10. Representation

a. The hearings provided for in this policy are for the purpose of intra-professional resolution of matters related to professional conduct, professional competency, or character. Accordingly, the Practitioner is entitled to representation at the hearing as follows:

i. If the Practitioner wishes to be accompanied at the hearing by an attorney, he or she shall provide written notice as soon as possible after CalOptima takes or recommends the action but not later than thirty (30) calendar days when requesting a hearing.

ii. CalOptima shall not be accompanied by an attorney if the Practitioner is not accompanied by an attorney. The foregoing shall not be deemed to deprive any party of its right to assistance of legal counsel for the purpose of preparing for a hearing.

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iii. If the Practitioner chooses not to be represented at the hearing by an attorney, he or she may be represented at the hearing by a licensed health care provider who is not also an attorney.

~~8.~~11. Pre-hearing Procedure

a. The Practitioner ~~or applicant~~ and the ~~agency~~peer review committee whose decision prompted the hearing shall exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural irregularities, as far in advance of the scheduled hearing as possible.

b. The Practitioner~~, applicant,~~ or ~~agency~~peer review committee whose decision prompted the hearing may raise ~~objectives~~objections to any pre-hearing decision at the hearing.

i. Such objections shall be preserved for consideration at any appellate review hearing.

ii. If the Practitioner~~, applicant,~~ or ~~agency~~peer review committee whose decision prompted the hearing fails to raise any objections at the hearing, such objections shall be deemed to have been waived.

~~9.~~12. Discovery

~~a. The affected Practitioner or applicant~~parties may inspect and copy, at his or her expense, any ~~documentary~~documents or other information relevant to the charges ~~that CalOptima, HN or PMG~~which the other party has in its possession or under its control~~.~~

~~b. The agency whose decision prompted the hearing may inspect and copy, at its expense, any documentary information relevant to the charges that the affected Practitioner or applicant has in his or her possession or under his or her control.~~

a. ~~CalOptima, a HN's a PMG, a Practitioner, and an applicant shall fulfill a request for discovery,~~ as soon as practicable~~.~~ after receipt of a request for the same.

~~c.~~b. Failure to comply with reasonable discovery requests at least thirty (30) calendar days prior to the hearing shall be good cause for a continuance of the hearing.

~~d.~~c. The hearing officer, at the request of either party to the hearing, may deny a discovery request if:

i. The information refers solely to individually identifiable Practitioners other than the affected Practitioner;

ii. The denial is justified to protect peer review; or

iii. The denial is justified ~~to project~~in the interest of justice.

~~e.~~d. In ruling on discovery disputes, the factors that may be considered include:

i. The information sought may be introduced to support or defend the charges;

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ii. The information is "exculpatory~~",~~" in that it would dispute or cast doubt upon the charges, or "inculpatory~~",~~" in that it would help support the charges or recommendation;

iii. The burden on the party of producing the requested information; and

iv. Other discovery requests made by the party.

~~10.~~13. Objections to the introduction of evidence previously not produced ~~for~~to CalOptima~~, HN or PMG~~.

a. ~~The agency whose decision prompted the hearing~~CalOptima may object to the introduction of evidence that was not provided during an application review, or during a peer review investigation conducted pursuant to policy, despite the requests of the ~~agency~~peer review committee whose decision prompted the hearing for the information.

b. The hearing officer shall bar such information from the hearing unless the Practitioner ~~or applicant~~ is able to prove that he or she previously acted diligently and could not have submitted the information.

~~11.~~14. Pre-hearing ~~Document~~Evidentiary Exchange

a. At the request of either party, the parties shall exchange a list of witnesses expected to testify, and copies of all documents that each party plans to introduce at the hearing.

b. The parties shall identify witnesses and exchange documents at least ten (10) calendar days prior to the hearing.

i. Failure to comply is good cause for the hearing officer to grant a continuance.

ii. This provision shall not affect the initial responsibility of the parties to make all relevant documents available for copying at least thirty (30) calendar days prior to the commencement of the hearing.

c. Failure to comply shall be good cause for the hearing officer to limit introduction of any documents not provided, or witnesses not identified, by the other party in a timely manner.

~~12.~~15. Record of Hearing

a. ~~The Judicial Review Committee shall maintain a record of the hearing by using a~~A certified shorthand reporter shall be present to make a record of the hearing proceedings. The pre-hearing proceedings may be placed on the record if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by CalOptima.

b. The Practitioner~~, applicant,~~ or ~~agency~~peer review committee whose decision prompted the hearing shall be entitled to receive a copy of the transcript or recording upon paying the reasonable cost for preparing the record. In such cases, both parties shall receive a copy of the transcript.

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~~c. The hearing officer may order that oral evidence be taken only if administered by a person designated by the Judicial Review Committee and entitled to notarize documents in California, or by affirmation under penalty of perjury to the hearing officer.~~

~~13.~~16. Rights of Parties

a. At the hearing, both parties shall have the right to:

i. Ask members of the Judicial Review Committee or the hearing officer questions directly related to determining if the members or the hearing officer meet the qualifications as set forth in Section ~~III~~IIIV.A.~~5~~6 and Section ~~III~~IIIV.A.~~7~~78 of this P~~p~~olicy, and to challenge the members or the hearing officer;

ii. Call and examine witnesses;

iii. Introduce exhibits and other relevant documents;

iv. Cross-examine or otherwise attempt to impeach any witness who testified orally on any matter relevant to the issues, and otherwise rebut any evidence;

v. Provide a written statement at the close of the hearing; and

vi. Be provided with all information made available to the Judicial Review Committee and to have a record made of the proceedings.

b. The ~~agency~~peer review committee whose decision prompted the hearing shall have the right to call and examine a Practitioner ~~or applicant~~ as if under cross-examination.

c. The hearing officer shall rule on any challenge directed at a member of the Judicial Review Committee or the hearing officer prior to the continuation of the proceedings.

~~14.~~17. Admissibility of Evidence

a. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence.

b. Any relevant evidence, including hearsay, shall be admitted by the hearing officer if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

c. The Judicial Review Committee members may question the witnesses, and may request that additional witnesses be called, if they deem it appropriate.

~~15.~~18. Burden of Going Forward and Burden of Proof

a. CalOptima~~, HN or PMG~~ shall have the initial duty to present evidence that supports the charge or recommended action. CalOptima is not required to prove each and every charge

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or issue before the Judicial Review Committee in order for its actions and/or recommendation(s) to be found reasonable and warranted.

b. TheAn initial applicant Practitioner shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that he or she possesses the requisite qualifications, experience, and competency to participate in CalOptima, HN or PMG programs.

i. An initial applicant Practitioner shall provide information that allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications to participate in CalOptima, HN or PMG.

ii. An initial applicant Practitioner shall not introduce information not produced upon CalOptima, HN or PMG'sCalOptima's request during the application process, unless the applicant Practitioner establishes that the information could not have been produced previously in the exercise of reasonable diligence.

iii.c. In all other casesExcept as provided above for initial applicants, CalOptima, HN or PMG shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

16.19. Adjournment and Conclusion

a. The Hearing Officer may adjourn and reconvene the hearing at the convenience of the participants without special notice.

b. The hearing shall be concluded within a reasonable time, and the hearing officer may set guidelines for introduction of evidence to achieve a timely conclusion.

c. The parties may submit a written statement at the close of the hearing, within guidelines as to length, format, and submission dates as decided by the hearing officer, in consultation with the Judicial Review Committee.

c.d. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The Judicial Review Committee shall thereupon, outside the presence of the parties, conduct its deliberations and render a decision and accompanying report.

d.e. Final adjournment shall not occur until the Judicial Review Committee has completed its deliberations.

17.20. Decision of the Judicial Review Committee

a. The Judicial Review Committee shall base its decision on all the evidence produced at the hearing, andincluding all logical and reasonable inferences from the evidence as well as any written statements submitted to the Judicial Review Committee.

b. Within thirty (30) calendar days after final adjournment of the hearing, the Judicial Review Committee shall render a decision accompanied by a written report that contains findings of

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fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision. If the Practitioner is under summary suspension, the time for the decision and report shall be within fifteen (15) days. The report shall be in sufficient detail to enable the parties and any appellate review body to determine the basis for the Judicial Review Committee's decision on each matter contained in the Notice of Charges. Such decision shall also contain an explanation of the procedure for appealing the decision.

c. The Judicial Review Committee shall forward the decision promptly but in not more than thirty (30) calendar days from the date the decision is rendered to the ~~agency~~peer review committee whose decision prompted the hearing, the CalOptima CMO, and ~~to~~ the affected Practitioner ~~or applicant~~.

d. The Judicial Review Committee shall deliver the Practitioner's copy of the report by registered or certified mail, return receipt requested, and first class mail.

e. The decision of the Judicial Review Committee shall be considered final~~, subject only to the~~ . There shall be no right ~~of~~to appeal ~~to~~the decision following the ~~appeal body~~formal hearing.

~~B. Appeals to the Appeal Agency~~

~~1. A Practitioner, applicant, or agency whose decision prompted the hearing may Appeal the Judicial Review Committee's decision within thirty (30) calendar days after receipt of the decision.~~

~~a. The Practitioner, applicant, or agency whose decision prompted the Hearing shall deliver the request by written notice, to the CMO, with a brief statement as to the grounds for Appeal.~~

~~b. If no appellate review is requested within such period, both sides shall be deemed to have accepted the action involved, and it shall become the final decision in the matter.~~

~~2. The appeal body shall schedule and arrange for an appellate review within forty (40) calendar days after receipt of a request for an Appeal.~~

~~a. The appeal body shall notify the Practitioner or applicant and the agency whose decision prompted the hearing of the time, place, and date of the appellate review.~~

~~b. The date shall be not less than forty (40) calendar days, or more than ninety (90) calendar days, from the date of receipt of the request for appellate review. However, if a Practitioner who is under suspension requests appellate review, the appeal body shall hold the appellate review as soon as arrangements may reasonably be made.~~

~~c. The appellate Hearing Officer may extend the time for appellate review by the appeal body for good cause.~~

~~3. The Quality Improvement Committee (QIC) may sit as the appeal body, or it may appoint an appeal board, which shall be composed of not fewer than three (3) members of the QIC.~~

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a. The appeal body shall designate a member as appeal chairperson. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal body, so long as that person did not participate in the matter at a previous level (i.e., as accuser, investigator, initial decision maker or panel member).

b. For purposes of this section, participation in an initial decision to recommend an investigation shall not be deemed to constitute participation at a previous level on this matter. If, however, a QIC member is disqualified by this section from serving as an appeal body member, he or she shall recuse him or herself from the Appeal.

c. The appeal body shall select an attorney to assist in the proceeding. He or she shall act as an appellate Hearing Officer and shall have all of the authority of, and carry out all of the duties assigned to, a hearing officer, as described in Section III.G of this policy. The attorney shall not be entitled to vote with respect to the Appeal.

d. The appeal body shall have such powers as are necessary to discharge its responsibilities.

e. The decision of the appeal body shall be a final decision of CalOptima, HN or PMG.

4. The proceedings by the appeal body shall be in the nature of a review of the record of the hearing before the Judicial Review Committee.

a. The appeal body shall exercise its independent judgment in determining if:

i. The Practitioner or applicant received a fair hearing;

ii. The decision is reasonable and warranted, and supported by the weight of the evidence; and

iii. Any provision of this policy, rule, or regulation relied on by the Judicial Review Committee in reaching its decision is reasonable and warranted.

b. The appeal body may accept additional oral or written evidence, subject to a foundational showing that such evidence could not be made available to the Judicial Review Committee in the exercise of reasonable diligence, and subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing.

c. The appeal body also may remand the matter to the Judicial Review Committee for the taking of further evidence and for a decision.

d. The appeal body shall give great weight to the recommendation of the agency whose action prompted the hearing. It shall not act arbitrarily or capriciously.

e. Each party shall have the right to present a written statement in support of his or her position on Appeal, the right to appear and present oral argument, the right to be represented by an attorney or any other representatives designated by the party, and the right to personally appear and respond.

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~~f. At the conclusion of oral argument, if requested, the appeal body may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the parties and their representatives.~~

~~g. The appeal body shall decide whether to affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision. Each party shall have the right to receive the written decision of the appeal body.~~

~~5. During the Appeals procedure, either party may request postponements and extensions of time beyond the times expressly permitted in this policy may. Such postponements and extensions may be permitted by the appeal body, its chairperson, or the appellate Hearing Officer acting upon its behalf, on a showing of good cause.~~

~~6. Decision~~

~~a. Within thirty (30) calendar days after the conclusion of the proceedings before the appeal body, the appeal body shall render a final decision in writing, and shall deliver copies in person or by certified mail, return receipt requested, and first class mail to the Practitioner or applicant, the CMO, and to the agency whose decision prompted the hearing.~~

~~b. Except for the matters referred for further review, the final decision of the appeal body following the Appeal procedure set forth in this Fair Hearing Plan shall be effective immediately and shall not be subject to further review. If the matter is remanded to the Judicial Review Committee, the Judicial Review Committee shall promptly conduct its review and make its recommendations to the appeal body, in accord with the instructions given by the appeal body. This further process and the report back to the appeal body shall in no event exceed thirty (30) calendar days in duration, except as the parties may otherwise stipulate.~~

~~c. The appeal body shall maintain a record of any additional review proceedings through use of a court reporter present to make a record of the hearing. The cost of preparation of a transcript of the proceedings shall be borne by the party requesting it. In such cases, both parties shall receive a copy of the transcript. The appeal body may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by a person designated by such body and entitled to notarize such documents in the State of California.~~

f. The decision of the Judicial Review Committee shall be transmitted to the CalOptima CMO. If the CalOptima CMO, in consultation with Legal Counsel, is satisfied that the Judicial Hearing Committee's decision follows from a fair hearing and is consistent with the applicable burden of proof as described above, it shall adopt that decision as the final action of CalOptima and the decision shall be effective immediately. If the CalOptima CMO, in consultation with Legal Counsel, concludes that the Judicial Hearing Committee's decision does not follow from a fair hearing and/or is inconsistent with the applicable burden of proof as described above, then the CMO, in consultation with Legal Counsel, shall proceed as it deems necessary and appropriate to address any unfairness and render a decision that is consistent.

21. Reporting

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a. CalOptima shall comply with the reporting requirements of Business and Professions Code and the National Practitioner Data Bank in accordance with CalOptima policy.

IV. ATTACHMENTS

~~Not Applicable~~

A. Notice of Hearing

V. REFERENCES

A. California Business and Professions Code, §§805 and 809
B. California Health and Safety Code, §1370
C. California Welfare and Institutions Code, §14000 et seq.
D. CalOptima Contract for Health Care Services
~~A.~~E. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~B.~~F. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima PACE Program Agreement
H. CalOptima Policy AA.1000: Glossary of Terms
I. CalOptima Policy CMC.1001: Glossary of Terms
J. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
K. CalOptima Policy MA.1001: Glossary of Terms
L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
M. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing ~~(2015)~~
~~C. California Welfare and Institutions Code, Section 14000 et seq.~~
~~D. California Business and Professions Code, Sections 805 and 809~~
~~E. California Health and Safety Code Section 1370~~
N. Title 42, Code of Federal Regulations (C.F.R.), ~~Section~~ §422.202
~~Title 42, Code of Federal Regulations (C.F.R.) Section §422.204~~
~~O. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing (2015)~~
~~F. CalOptima Policy AA.1000: Glossary of Terms~~
~~OneCare~~ ~~CalOptima Policy CMC.1001: Glossary of Terms~~
~~G. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities CalOptima Policy MA.1001: Glossary of Terms~~

VI. REGULATORY AGENCY APPROVALS ~~OR~~

None to Date

~~VI.~~VII. BOARD ACTIONS

~~Not Applicable~~

~~None to Date~~A. 06/01/17: Regular Meeting of the CalOptima Board of Directors

~~VII.~~VIII. REVIEW/REVISION HISTORY

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~~A. 6/1/14: GG.1616: Fair Hearing Plan for Practitioners (Review)~~
~~B. 2/1/13: GG.1616: Fair Hearing Plan for CalOptima Direct Practitioners~~
~~C. 11/1/11: GG.1616: Fair Hearing Plan for CalOptima Direct Practitioners~~
~~D. 4/1/07: GG.1616: Fair Hearing Plan for CalOptima Direct Practitioners~~
~~E. 3/1/07: MA.7016: Fair Hearing Plan for Practitioners~~
~~F. 10/1/05: MA.7016: Fair Hearing Plan for Practitioners~~
~~G. 2/03: GG.1616: Fair Hearing Plan for CalOptima Direct Practitioners~~
~~H. 3/99: GG.1616: Fair Hearing Plan for CalOptima Direct Practitioners~~
~~I. 4/96: GG.1616: Fair Hearing Plan for CalOptima Direct Practitioners~~

Version	**~~Version~~ Date**	**Policy Number**	**Policy Title**	**Line(s) of Business**
~~Original Date~~Effective	04/1996	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
~~Revision Date 1~~Revised	03/1999	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised~~Revision Date 2~~	02/2003	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised~~Revision Date 3~~	10/01/2005	MA.7016	Fair Hearing Plan for Practitioners	OneCare
Revised~~Revision Date 4~~	03/01/2007	MA.7016	Fair Hearing Plan for Practitioners	OneCare
Revised~~Revision Date 5~~	04/01/2007	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised~~Revision Date 6~~	11/01/2011	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised~~Revision Date 7~~	02/01/2013	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Review~~ Date 1~~ed	06/01/2014	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal
Revised~~Revision Date 8~~	06/01/2017	GG.1616Δ	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE

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~~VIII.~~IX. ~~DEFINITIONS~~GLOSSARY

Term	Definition
Health Network	For purpose of this policy, a Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Judicial Review Committee	The committee appointed to conduct a hearing based on a request for hearing by a Practitioner as described in this policy.
Minimum Physician Standards	The standards that must be met in order to submit an application for credentialing, the successful approval of which is a prerequisite to contracting with CalOptima or Health Networks in accordance with CalOptima Policy GG.1643: Minimum Physician Standards.
Peer Review	The process of reviewing whether a Practitioner is qualified, on an initial and ongoing basis, to participate in health care programs administered by CalOptima (including through delegated Health Networks) and taking actions, as appropriate, based on such review.
Practitioner	For the purposes of this Policy, "Practitioner" shall have the same meaning as "Licentiate" as that term is defined in Section 805 of the California Business and Professions Code and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168.

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Policy #: GG.1616Δ
Title: **Fair Hearing Plan for Practitioners**
Department: Medical Affairs
Section: Quality Improvement

CEO Approval: Michael Schrader

Effective Date: 4/96
Last Review Date: 06/01/17
Last Revised Date: 06/01/17

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

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I. PURPOSE

This policy defines the process that CalOptima shall use to provide a fair procedure to Practitioners when adverse actions are proposed to be taken or are taken by CalOptima and for which a report is required to be filed under California Business and Professions Code Section 805 of the and/or with the National Practitioner Data Bank (NPDB).

II. POLICY

A. CalOptima shall offer Practitioners the procedural rights set forth in this Policy.

B. A Peer Review investigation may be initiated by CalOptima whenever reliable information indicates a Practitioner may have engaged in actions which adversely affect or could adversely affect the health or welfare of a CalOptima Member and may call into question his or her competence or professional conduct.

C. In the event CalOptima believes an adverse action is warranted, as a result of the peer review investigation, CalOptima shall provide written notice to the Practitioner, within thirty (30) calendar days of the decision of the adverse recommendation and the right to request a hearing as provided in this Policy.

D. A Practitioner may request a hearing if CalOptima would be required to file a report pursuant to Section 805 of the California Business and Professions Code and/or National Practitioner Data Bank requirements based on one (1) or more of the following actions:

1. CalOptima Initiated Actions:

   a. Denial of a Practitioner's application for CalOptima participation for a medical disciplinary cause or reason;

   b. Non-renewal of a Practitioner's CalOptima participation for a medical disciplinary cause or reason;

c. Restriction on a Practitioner's CalOptima participation for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a medical disciplinary cause or reason;

d. Termination of a Practitioner's CalOptima participation for a medical disciplinary cause or reason; and

e. Imposition of summary suspension of a Practitioner's CalOptima participation for a medical disciplinary cause or reason if the summary suspension remains in effect for more than fourteen (14) calendar days.

2. Practitioner-Initiated Actions:

a. Resignation or leave of absence by a Practitioner from CalOptima participation after: (i) notice of an investigation initiated for a medical disciplinary cause or reason; or (ii) notice that his or her application is denied or will be denied for a medical disciplinary cause or reason;

b. Withdrawal or abandonment of a Practitioner's application for CalOptima participation after: (i) notice of an investigation initiated for a medical disciplinary cause or reason; or (ii) notice that his or her application is denied or will be denied for a medical disciplinary cause or reason;

c. Withdrawal or abandonment of a Practitioner's request for renewal of CalOptima participation after: (i) notice of an investigation initiated for a medical disciplinary cause or reason; or (ii) notice that his or her application is denied or will be denied for a medical disciplinary cause or reason.

3. Other Disciplinary Actions

a. Any other disciplinary action or recommendation that must be reported to the Medical Board and/or the National Practitioner Data Bank.

E. Except as otherwise provided in this Policy, no Practitioner shall be entitled, as a matter of right, to more than one (1) hearing on any matter.

F. With respect to the entirety of this process, technical, insignificant, or non-prejudicial deviations from the procedures set forth in this process shall not be grounds for invalidating the action taken.

G. If adverse action, as described in CalOptima Policy GG.1607Δ: Monitoring Adverse Activities, is taken or recommended, a Practitioner shall exhaust all remedies afforded by this Policy before resorting to legal action. If a Practitioner fails to exhaust all remedies afforded by this Policy, CalOptima shall deem such Practitioner to have waived all hearing and appeal requirements and to have accepted CalOptima's action or recommendation.

H. This policy does not apply to the imposition of administrative restrictions, suspensions, or terminations resulting from the Practitioner's failure to meet specific credentialing and contractual obligations including, without limitation, the failure to meet Minimum Physician Standards, or where restrictions, suspensions, or terminations are not based on a medical disciplinary cause or reason.

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I. The hearing process described in this policy may not be used to challenge any established law, rule, regulation, policy, or requirement and the Judicial Review Committee has no authority to make findings or decisions to modify, limit, or overrule any established law, rule, regulation, policy, or requirement and it shall not entertain any such challenge.

J. Unless a summary suspension is imposed, if the Practitioner waives his or her procedural rights, then the recommendation of CalOptima shall be submitted for final action, as provided in Section III.A.20.f.

K. Health Networks shall have policies and procedures consistent with this policy that provide Practitioners with formal appeal rights when the Health Network takes or proposes adverse action for which a report is required to be filed under Section 805 of the California Business and Professions Code and/or with the NPDB.

III. PROCEDURE

A. Hearing Procedure

1. Notice of Action

a. If CalOptima takes or recommends any of the final actions described in Section II.D. of this Policy, CalOptima shall provide written notice as soon as possible after CalOptima takes or recommends the action but not later than thirty (30) calendar days thereafter to the Practitioner of the action or recommendation, and the Practitioner's right to a hearing.

b. The notice shall include:

i. The action or recommendation against the Practitioner;

ii. CalOptima's obligation to report such action, if adopted, in accordance with Section 805 of the California Business and Professions Code and/or National Practitioner Data Bank requirements;

iii. A brief statement of the reasons for the action or recommendation;

iv. The Practitioner's right to request a hearing within thirty (30) calendar days after the date of the notice; and

v. A copy of this Fair Hearing Plan Policy.

2. Request for Hearing

a. A Practitioner shall request a hearing by a Judicial Review Committee within thirty (30) calendar days after the date of receipt of the notice described in Section III.A.1 of this Policy.

b. The Practitioner shall request such hearing in writing to the CalOptima Chief Medical Officer (CMO), or designee, as applicable.

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c. If the Practitioner fails to request a hearing in accordance with Sections III.A.2.a and III.A.2.b of this policy, CalOptima shall deem such Practitioner to:

i. Have waived the right to a hearing and to any appellate review for which he or she may have been eligible under this policy; and

ii. Have accepted CalOptima's action or final proposed action, which shall thereupon become effective immediately.

3. Hearing Schedule

a. Upon receipt of a Practitioner's written request for a hearing, CalOptima shall deliver such request to the peer review committee whose decision prompted the hearing.

b. The hearing shall commence not less than thirty (30) calendar days and not more than sixty (60) calendar days after the date the CMO receives the Practitioner's request for a hearing.

i. CalOptima may extend the time for commencement of the hearing, but in the event the request is received from a Practitioner who is under summary suspension, the hearing shall be held as soon as arrangements may be reasonably made, so long as the Practitioner has at least thirty (30) calendar days from the date of the notice to prepare for the hearing or provides written waiver of this right;

ii. CalOptima and the Practitioner may agree, in writing, to delay the hearing; or

iii. The hearing officer may issue a written decision to delay the hearing on a showing of good cause.

4. Notice of Hearing (Charges)

a. If the Practitioner makes a request for a hearing on a timely basis, CalOptima shall provide written notice of the hearing to the Practitioner at least thirty (30) calendar days prior to the date of the hearing.

b. Such notice shall include:

i. The time, date, and location of the hearing;

ii. The reason(s) for the final proposed action taken or recommended, including acts or omissions with which the Practitioner is charged and a list of the patients whose care is in question, where applicable; or, if the action involves denial of a Practitioner's application for participation, the reason(s) for the denial; and

iii. A summary of the Practitioner's rights and the hearing process.

c. CalOptima may amend the Notice of Hearing at any time so long as the Practitioner has reasonable opportunity to prepare for and present a defense to the amended charges.

5. Judicial Review Committee

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a. Upon receipt of a request for a hearing, the CalOptima CMO shall appoint a Judicial Review Committee, at least a majority of whom shall be peers of the Practitioner, and shall designate a chairperson. The Judicial Review Committee shall be composed of not less than three (3) members.

b. The chairperson shall hear all pre-hearing matters until the selection of a hearing officer.

c. All members of the Judicial Review Committee shall be present at each hearing session, Judicial Review Committee meeting, and deliberation session unless both parties agree that any one (1) member need not attend a particular session or meeting.

d. The decision of the Judicial Review Committee shall be by a majority vote of the members. The numerical vote shall be recorded.

6. Arbitrator

a. CalOptima may propose that an arbitrator be selected in lieu of a Judicial Review Committee. The use of an arbitrator shall be subject to mutual agreement by CalOptima and the Practitioner. If an arbitrator is used, the process described in Section III.A.6.b. of this policy will apply.

b. The arbitrator shall meet the same qualifications as the hearing officer and will be selected using a process mutually acceptable to CalOptima and the Practitioner. If the parties are unable to agree, the arbitrator will be selected pursuant to JAMS Comprehensive Arbitration Rules & Procedures. If an arbitrator is selected, no separate Judicial Review Committee or hearing officer shall be appointed and all references in this Policy to the Judicial Review Committee or hearing officer duties and responsibilities shall be read as applicable to the arbitrator.

7. Hearing Officer

a. The CalOptima CMO shall appoint a hearing officer to preside at the hearing.

i. The hearing officer shall be an attorney at law qualified to preside over a hearing, and preferably shall have experience in medical staff disciplinary matters.

ii. The hearing officer shall:

a) Not be biased for or against the Practitioner;

b) Gain no direct financial benefit from the outcome; and

c) Not act as a prosecuting officer or as an advocate for any party.

b. The hearing officer shall participate in the deliberations, and act as a legal advisor to the Judicial Review Committee, but shall not be entitled to vote.

c. The hearing officer shall ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained.

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d. The hearing officer shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing.

e. The hearing officer shall have the authority and discretion, in accordance with this policy, to:

i. Grant continuances;

ii. Determine when attorneys may be permitted;

iii. Rule on challenges to Judicial Review Committee members;

iv. Rule on challenges to himself or herself serving as the hearing officer;

v. Rule on questions raised prior to, or during, the hearing pertaining to matters of law, procedures, or the admissibility of evidence;

vi. Exercise discretion in limiting the number of witnesses and the overall amount of evidence introduced at the hearing;

vii. Impose any safeguards for the protection of the Peer Review process and, as justice requires, pursuant to Business and Professions Code Section 809.2;

viii. If requested by the Judicial Review Committee, assist in preparation of the Judicial Review Committee's report and recommendations; and

ix. Take such action as may be warranted by the circumstances if the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner.

8. Failure to Appear

a. A Practitioner's failure to appear and proceed at the hearing, absent good cause, shall be deemed voluntary acceptance of the recommendation or action. In such cases, the matter will be forwarded for final action as provided in Section III.A.20.f of this Policy.

9. Postponements and Extensions

a. Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted under this policy may be allowed by the hearing officer on a showing of good cause or upon agreement of parties.

b. Extensions of time necessary to appoint a Judicial Review Committee, hearing officer, and/or arbitrator shall be deemed good cause as long as both parties proceed in good faith.

10. Representation

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a. The hearings provided for in this policy are for the purpose of intra-professional resolution of matters related to professional conduct, professional competency, or character. Accordingly, the Practitioner is entitled to representation at the hearing as follows:

i. If the Practitioner wishes to be accompanied at the hearing by an attorney, he or she shall provide written notice as soon as possible after CalOptima takes or recommends the action but not later than thirty (30) calendar days when requesting a hearing.

ii. CalOptima shall not be accompanied by an attorney if the Practitioner is not accompanied by an attorney. The foregoing shall not be deemed to deprive any party of its right to assistance of legal counsel for the purpose of preparing for a hearing.

iii. If the Practitioner chooses not to be represented at the hearing by an attorney, he or she may be represented at the hearing by a licensed health care provider who is not also an attorney.

11. Pre-hearing Procedure

a. The Practitioner and the peer review committee whose decision prompted the hearing shall exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural irregularities, as far in advance of the scheduled hearing as possible.

b. The Practitioner or peer review committee whose decision prompted the hearing may raise objections to any pre-hearing decision at the hearing.

i. Such objections shall be preserved for consideration at any appellate review hearing.

ii. If the Practitioner or peer review committee whose decision prompted the hearing fails to raise any objections at the hearing, such objections shall be deemed to have been waived.

12. Discovery

a. The parties may inspect and copy, at his or her expense, any documents or other information relevant to the charges which the other party has in its possession or under its control, as soon as practicable after receipt of a request for the same.

b. Failure to comply with reasonable discovery requests at least thirty (30) calendar days prior to the hearing shall be good cause for a continuance of the hearing.

c. The hearing officer, at the request of either party to the hearing, may deny a discovery request if:

i. The information refers solely to individually identifiable Practitioners other than the affected Practitioner;

ii. The denial is justified to protect peer review; or

iii. The denial is justified in the interest of justice.

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d. In ruling on discovery disputes, the factors that may be considered include:

i. The information sought may be introduced to support or defend the charges;

ii. The information is "exculpatory," in that it would dispute or cast doubt upon the charges, or "inculpatory," in that it would help support the charges or recommendation;

iii. The burden on the party of producing the requested information; and

iv. Other discovery requests made by the party.

13. Objections to the introduction of evidence previously not produced to CalOptima.

a. CalOptima may object to the introduction of evidence that was not provided during an application review, or during a peer review investigation conducted pursuant to policy, despite the requests of the peer review committee whose decision prompted the hearing for the information.

b. The hearing officer shall bar such information from the hearing unless the Practitioner is able to prove that he or she previously acted diligently and could not have submitted the information.

14. Pre-hearing Evidentiary Exchange

a. At the request of either party, the parties shall exchange a list of witnesses expected to testify, and copies of all documents that each party plans to introduce at the hearing.

b. The parties shall identify witnesses and exchange documents at least ten (10) calendar days prior to the hearing.

i. Failure to comply is good cause for the hearing officer to grant a continuance.

ii. This provision shall not affect the initial responsibility of the parties to make all relevant documents available for copying at least thirty (30) calendar days prior to the commencement of the hearing.

c. Failure to comply shall be good cause for the hearing officer to limit introduction of any documents not provided, or witnesses not identified, by the other party in a timely manner.

15. Record of Hearing

a. A certified shorthand reporter shall be present to make a record of the hearing proceedings. The pre-hearing proceedings may be placed on the record if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by CalOptima.

b. The Practitioner or peer review committee whose decision prompted the hearing shall be entitled to receive a copy of the transcript or recording upon paying the reasonable cost for preparing the record. In such cases, both parties shall receive a copy of the transcript.

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16. Rights of Parties

    a. At the hearing, both parties shall have the right to:

        i. Ask members of the Judicial Review Committee or the hearing officer questions directly related to determining if the members or the hearing officer meet the qualifications as set forth in Section III.A.5 and Section III.A.7 of this Policy, and to challenge the members or the hearing officer;

        ii. Call and examine witnesses;

        iii. Introduce exhibits and other relevant documents;

        iv. Cross-examine or otherwise attempt to impeach any witness who testified orally on any matter relevant to the issues, and otherwise rebut any evidence;

        v. Provide a written statement at the close of the hearing; and

        vi. Be provided with all information made available to the Judicial Review Committee and to have a record made of the proceedings.

    b. The peer review committee whose decision prompted the hearing shall have the right to call and examine a Practitioner as if under cross-examination.

    c. The hearing officer shall rule on any challenge directed at a member of the Judicial Review Committee or the hearing officer prior to the continuation of the proceedings.

17. Admissibility of Evidence

    a. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence.

    b. Any relevant evidence, including hearsay, shall be admitted by the hearing officer if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

    c. The Judicial Review Committee members may question the witnesses, and may request that additional witnesses be called, if they deem it appropriate.

18. Burden of Going Forward and Burden of Proof

    a. CalOptima shall have the initial duty to present evidence that supports the charge or recommended action. CalOptima is not required to prove each and every charge or issue before the Judicial Review Committee in order for its actions and/or recommendation(s) to be found reasonable and warranted.

    b. An initial applicant Practitioner shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that he or she possesses the requisite qualifications, experience, and competency to participate in CalOptima programs.

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i. An initial applicant Practitioner shall provide information that allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications to participate.

ii. An initial applicant Practitioner shall not introduce information not produced upon CalOptima's request during the application process, unless the applicant Practitioner establishes that the information could not have been produced previously in the exercise of reasonable diligence.

c. Except as provided above for initial applicants, CalOptima shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

19. Adjournment and Conclusion

a. The Hearing Officer may adjourn and reconvene the hearing at the convenience of the participants without special notice.

b. The hearing shall be concluded within a reasonable time, and the hearing officer may set guidelines for introduction of evidence to achieve a timely conclusion.

c. The parties may submit a written statement at the close of the hearing, within guidelines as to length, format, and submission dates as decided by the hearing officer, in consultation with the Judicial Review Committee.

d. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The Judicial Review Committee shall thereupon, outside the presence of the parties, conduct its deliberations and render a decision and accompanying report.

e. Final adjournment shall not occur until the Judicial Review Committee has completed its deliberations.

20. Decision of the Judicial Review Committee

a. The Judicial Review Committee shall base its decision on all the evidence produced at the hearing, including all logical and reasonable inferences from the evidence as well as any written statements submitted to the Judicial Review Committee.

b. Within thirty (30) calendar days after final adjournment of the hearing, the Judicial Review Committee shall render a decision accompanied by a written report that contains findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision. If the Practitioner is under summary suspension, the time for the decision and report shall be within fifteen (15) days. The report shall be in sufficient detail to enable the parties and any appellate review body to determine the basis for the Judicial Review Committee's decision on each matter contained in the Notice of Charges. Such decision shall also contain an explanation of the procedure for appealing the decision.

c. The Judicial Review Committee shall forward the decision promptly but in not more than thirty (30) calendar days from the date the decision is rendered to the peer review

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committee whose decision prompted the hearing, the CalOptima CMO, and the affected Practitioner.

d. The Judicial Review Committee shall deliver the Practitioner's copy of the report by registered or certified mail, return receipt requested, and first class mail.

e. The decision of the Judicial Review Committee shall be considered final. There shall be no right to appeal the decision following the formal hearing.

f. The decision of the Judicial Review Committee shall be transmitted to the CalOptima CMO. If the CalOptima CMO, in consultation with Legal Counsel, is satisfied that the Judicial Hearing Committee's decision follows from a fair hearing and is consistent with the applicable burden of proof as described above, it shall adopt that decision as the final action of CalOptima and the decision shall be effective immediately. If the CalOptima CMO, in consultation with Legal Counsel, concludes that the Judicial Hearing Committee's decision does not follow from a fair hearing and/or is inconsistent with the applicable burden of proof as described above, then the CMO, in consultation with Legal Counsel, shall proceed as it deems necessary and appropriate to address any unfairness and render a decision that is consistent.

21. Reporting

a. CalOptima shall comply with the reporting requirements of Business and Professions Code and the National Practitioner Data Bank in accordance with CalOptima policy.

IV. ATTACHMENTS

A. Notice of Hearing

V. REFERENCES

A. California Business and Professions Code, §§805 and 809
B. California Health and Safety Code, §1370
C. California Welfare and Institutions Code, §14000 et seq.
D. CalOptima Contract for Health Care Services
E. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima PACE Program Agreement
H. CalOptima Policy AA.1000: Glossary of Terms
I. CalOptima Policy CMC.1001: Glossary of Terms
J. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
K. CalOptima Policy MA.1001: Glossary of Terms
L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
M. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing
N. Title 42, Code of Federal Regulations (C.F.R.), §422.202
O. Title 42, Code of Federal Regulations (C.F.R.) §422.204

VI. REGULATORY AGENCY APPROVALS

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None to Date

VII. BOARD ACTIONS

A. 06/01/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/1996	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	03/1999	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	02/2003	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	10/01/2005	MA.7016	Fair Hearing Plan for Practitioners	OneCare
Revised	03/01/2007	MA.7016	Fair Hearing Plan for Practitioners	OneCare
Revised	04/01/2007	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	11/01/2011	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	02/01/2013	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Reviewed	06/01/2014	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal
Revised	06/01/2017	GG.1616Δ	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Health Network	For purpose of this policy, a Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Judicial Review Committee	The committee appointed to conduct a hearing based on a request for hearing by a Practitioner as described in this policy.
Minimum Physician Standards	The standards that must be met in order to submit an application for credentialing, the successful approval of which is a prerequisite to contracting with CalOptima or Health Networks in accordance with CalOptima Policy GG.1643: Minimum Physician Standards.
Peer Review	The process of reviewing whether a Practitioner is qualified, on an initial and ongoing basis, to participate in health care programs administered by CalOptima (including through delegated Health Networks) and taking actions, as appropriate, based on such review.
Practitioner	For the purposes of this Policy, "Practitioner" shall have the same meaning as "Licentiate" as that term is defined in Section 805 of the California Business and Professions Code and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168.

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[Date]

[Recipient Name]
[Street Address]
[City, ST ZIP Code]

Dear [Recipient Name]:

The purpose of this letter is to provide you with notice that the CalOptima Credentialing and Peer Review Committee (CPRC) has reviewed concerns regarding the quality of your care and has subject to fair hearing rights, determined to deny your credentialing application for CalOptima participation for a medical disciplinary cause or reason, per CalOptima Policy GG.1616 (a copy of this policy is enclosed for your reference).

In reaching its decision, the CPRC has reviewed and considered, by way of example, the following: [ADD DETAIL]

Notice of Procedural Rights:

Please be advised that you are entitled to the procedural rights set forth in CalOptima's Corrective Action Plan for Practitioners Policy No. GG.1615 and Fair Hearing Plan for Practitioners Policy No. GG.1616.

PLEASE BE ADVISED THAT YOU HAVE THIRTY (30) DAYS FROM THE DATE OF RECEIPT OF THIS LETTER TO REQUEST A HEARING. YOUR REQUEST SHALL BE MADE IN WRITING AND DIRECTED TO: RICHARD HELMER, MD, CALOPTIMA CHIEF MEDICAL OFFICER. FAILURE TO REQUEST A HEARING WITHIN THIRTY (30) DAYS WILL RESULT IN A WAIVER OF YOUR RIGHT TO A HEARING AND ANY APPELLATE REVIEW AND THE RECOMMENDATIONS OF THE CPRC SHALL BE DEEMED ACCEPTED AND FINAL

If you timely elect to exercise your right to challenge the recommended restriction, you will have a right to a written notice of the time, date and place of the hearing, to a notice of the charges, the

right to inspect and copy documentary information, to ask questions and challenge the qualifications of Judicial Review Committee members or the hearing officer, to submit documents in your defense, to call and examine witnesses, to introduce exhibits and other relevant documents, to cross-examine and impeach witnesses, to testify on your behalf, to rebut evidence, to provide a written statement at the close of the hearing, to be provided with information made available to the Judicial Review Committee and have a record made of the proceedings, to be provided with a copy of the decision, and to appeal any decision.

Very Truly yours,

Richard Bock, MD, MBA
Deputy Chief Medical Officer

cc: Richard Helmer, MD, Chief Medical Officer
Michael Schrader, Chief Executive Officer
CalOptima Quality Improvement Committee
CalOptima Credentialing and Peer Review Committee

Enclosure

Policy #:	GG.1607Δ
Title:	**Monitoring Adverse ~~Activity Process~~Activities**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader
Effective Date:	12/95
Last Review Date:	06/01/17
Last Revised Date:	06/01/17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~CEO Approval: Michael Schrader~~

~~Effective Date: 12/95 Revised: 8/98, 11/99, 3/1/07, 4/1/07, 11/1/11, 2/1/13, 6/1/14~~

~~I.~~

I. PURPOSE

~~To establish~~This policy establishes a process for ongoing monitoring of ~~Practitioners~~contracted or non-contracted practitioners and Healthcare Delivery Organization's (~~HDO's~~HDOs) Adverse Activity ~~during the interval between formal Credentialing and any action taken against Practitioner or HDOs for adverse actions, including, quality issues.~~.

II. ~~POLICY~~

A. ~~A.~~ CalOptima shall perform ongoing monitoring of ~~Practitioner~~practitioner or HDO ~~Sanctions, Complaints~~sanctions, complaints, and quality issues between R~~r~~ecredentialing cycles.

B. A Health Network shall perform ongoing monitoring of practitioner or HDO sanctions, complaints, and quality issues between Recredentialing cycles~~.~~ that at a minimum, is in accordance with this P~~p~~olicy.

C. ~~B.~~ CalOptima shall take appropriate action against ~~Practitioners~~practitioners or HDOs when the CalOptima Quality Improvement (QI) Department identifies ~~occurrences of poor quality.~~ adverse activity.

D. CalOptima shall notify practitioners and HDOs if limiting practice, in writing, within thirty (30) calendar days.

~~A.~~E. Adverse Activities include ~~any of~~, but are not limited to the following:

1. Any adverse action by the Medical Board of California, taken or pending, including, but not limited to, an accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter of reprimand, or any formal restriction, probation, suspension, or revocation of licensure, or cease of practice with charges pending;

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2. An adverse action taken by any health care organization or a Peer Review Body (as defined in State or Federal law), or other organizations, that has resultedresults in the filing of a Section 805report under Business & Professions Code Sections 805 or 805.01 report with the Medical Board of California (within fifteen (15) calendar days), and/or a report with the National Practitioner Data Bank (NPDB) (within thirty (30) calendar days););

   a. Outcomes which may require reporting to authorities are based on California Business and Professions Code section 805.01.

      i. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public.

      ii. The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022 of the Business and Professions code, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.

      iii. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefore; and

      iv. Sexual misconduct with one or more patients during a course of treatment or an examination;

3. A revocation of a Drug Enforcement Agency (DEA) license;

4. A conviction of a felony or misdemeanor of moral turpitude;

5. Any action against a certification under the Medicare or Medicaid programs;

6. A cancellation, non-renewal, or material reduction in medical liability insurance policy coverage;

7. Any action taken by the California Department of Public Health Care Services, Division of Licensing and Certification;

8. Any action taken by the Health and Human Services Office of the Inspector General (OIG); and

9. Any action taken by System for Award Management (SAM); orand;

9.10. A pattern or trend concerning quality of care issues and Complaints complaints that have been identified through the CalOptima Quality Improvement Department.

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D. CalOptima shall inform Practitioners or HDOs of the formal appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policy GG.1616A: Fair Hearing Plan for Practitioners and this policy.

III. PROCEDURE

i. CalOptima Practitionersmonitors practitioners and HDOs shall be subject to on an ongoing monitoring as a result of CalOptima's identification of basis to identify Adverse Activities, as described that may affect participation in Section III.B.1of this policy.

A. CalOptima shall monitorprogram.

ii.B. CalOptima monitors various State Licensing Boards, and State and Federal Agencies in order to timely identify any Practitioners or HDOs withboards, agencies, and databanks for Adverse Activity(ies),.) including:

1. OIG exclusion list: monthly, as well as during the time of initialupon Credentialing and Recredentialing and ongoing on a monthly basis;

2. SAM list:; upon Credentialing and Recredentialing and ongoing on a monthly basis;

3. Business & Professions Code Sections 805 and 805.01, and continuous monitoring NPDB reports;

2.4. Medicare Opt-Out Physicians: monitoredupon Credentialing and Recredentialing and ongoing on a quarterly during the time of initial Credentialing and Recredentialingbasis;

3.5. Medi-Cal Provider Suspended and Ineligible list: monthlyupon Credentialing and Recredentialing and ongoing on a monthly basis ; and

4.6. Medical Board of California notifications: as published via e-mail notifications of license suspensions, restrictions, revocations, surrenders and disciplinary actions ;; and.

5. State Licensing Boards for all practitioners credentialed and contracted with CalOptima: monthly and quarterly as reports are published;

6.C. CalOptima shall review all information gathered from the specified Websites within thirty (30) calendar days of its release; and.

D. Any adverse activity that limits or removes a practitioner's right to practice will be reported via Provider Alert to the Quality Medical Director for approval. Once approved, the Provider Relations or Health Network Relations Departments will be notified. In addition, Provider Data Management Services (PDMS) will be notified and will enter an alert in Facets™ which will also be captured in Guiding Care for the UM staff's notification.

E. Any adverse activities identified shall be tracked in the adverse activity database.

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F. Upon credentialing and recredentialing, adverse activities identified in the tracking database will be summarized and added to the practitioner and HDO file in Credentialing database.

7.G. On a quarterlybi-monthly basis, the or earlier, depending on the nature of the adverse activity and CalOptima requirements, the QI Department shall report, in a confidential manner, all findings to the Credentialing and Peer Review Committee (CPRC).

8.H. On a quarterly basis, CalOptima's Grievance & Appeals Resolution Services (GARS) Department shall report to the Quality Improvement Committee (QIC) all complaints, including a summary of data analysis, regarding service, attitude, and access, in accordance with CalOptima Policy 1608Δ: Full Scope Site ReviewsPolicies CMC.9001: Member Complaint Process, CMC.9002: Member Grievance Process, HH.1102: CalOptima Member Complaint, MA.9002: Member Grievance Process.

C.I. The QI Department shall monitorforward all Practitioners Practitioner and HDOsHDO potential quality issues (PQI) as received from internal and external sources, to a CalOptima Medical Director for review and potential action, in accordance with CalOptima Policy GG.1611: Potential Quality Improvement CaseIssue Review Process.

B. The QI Department CalOptima shall investigate PQI by compiling Medical Records and responses to Complaints from Providers and HDOs.

C.

J. A physician reviewer or inform affected practitioners or HDOs of the CPRC shall review appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

D. case and determine if any quality of care issues are identified.

E.

D. The QI Department shall enter into the Quality Improvement database, and note on the Practitioner's or HDO's credentialing file, a Practitioner or HDO with Adverse Activity.

E. The CPRC shall review information concerning Practitioners and HDOs with Adverse Activity and implement actions accordingly:

1. Upon conclusion of the investigation, the CPRC shall determine whether any corrective action is necessary, and whether the corrective action, is recommended as a result of a "medical disciplinary cause or reason."

2. In accordance with CalOptima Policy GG.1611: Quality Improvement Case Review Process, the summary of the corrective action(s) recommended by the CPRC shall include, without limitation, the following:

a. Determination of whether a quality issue exists;

b. If no quality issue is identified, no further action regarding the review process shall occur, and CalOptima shall forward the case summary to the Practitioner or HDO for closure;

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c. If a potential quality issue is identified, the CPRC shall review the findings, and may recommend:

i. Review of the case by a multidisciplinary team of Practitioners s or HDOs; and/or

ii. Peer review of the case by a medical specialist, when required, relevant to the Practitioner or HDO issue involved in the case;

d. If a quality issue is identified, the CPRC shall take the following action:

i. Request corrective action from a specific CalOptima Department, Health Network, or Practitioner or HDO;

ii. Require the Health Network or CalOptima to perform additional educational training; or

iii. Other appropriate action as defined by the CPRC.

F.K. CalOptima's Quality Improvement Department shall maintain Credentialing information in a Credentialing file, in accordance with CalOptima Policy GG1604AGG.1604Δ: Confidentiality of Credentialing Files, and shall ensure that all Credentialing files are up-to-date.-.

G. Practitioner and HDO Appeal Rights

1. CalOptima shall inform affected Practitioners and HDOs of the Appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policy GG1616Δ: Fair Hearing Plan for Practitioners. The written notification shall inform Practitioners and HDOs of:

a. Any professional review action taken against the Practitioner or HDO, as well as reasons for the action, and a summary of the appeal rights and process;

b. The Practitioner or HDO's right to request a hearing, and the specific time period for submitting the request;

c. The Practitioners or HDO's right to request a hearing after thirty (30) days of receipt of the notification;

d. The Practitioners or HDO's right to representation by an attorney or another person of the Practitioner or HDO's choosing; and

e. The CalOptima Chief Medical Officer's right to appoint a hearing officer or a panel of individuals to review the appeal.

L. All suspensions and, terminations from any licensing or regulating agency will be reported through the Regulatory Affairs & Compliance Department to the Department of Health Care Services (DHCS) within ten (10) days of final notification to CalOptima.

a. The report to DHCS shall include the following:

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i. Contract status (by delegated entity, if applicable) with the named provider.

ii. The number of beneficiaries receiving services from the provider by all lines of business including any delegated entity, LTSS, or OneCare Connect.

M. Any alert affecting Health Networks will be communicated through the Health Network Relations Department, as applicable.

N. Any alert that may affect provider directories will follow processes outlined in CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-Based Directory.

IV. ATTACHMENTS

A. Ongoing Monitoring Website Information Matrix

V. REFERENCES

A. California Business and Professions Code, §§805 and 805.01
B. California Business and Professions Code, §4022
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
CalOptima PACE Program AgreementsCalifornia Business and Professions Code, §§ 805 and 805.01
A. California Business and Professions Code, Sections 805 and §4022
B. CalOptima PACE Program Agreement
E. Title 42 United States Code §11101 et seq.
C.F. CalOptima Policy AA.1000: Glossary of TermsCMC.9001: Member Complaint Process
G. CalOptima Policy CMC.9002: Member Grievance Process
D.H. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
E. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
F.I. CalOptima Policy GG.1611: Potential Quality Improvement CaseIssue Review Process
G.J. CalOptima Policy GG.1615: CalOptima Direct Corrective Action Plan for Practitioners
H.K. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
L. OneCareCalOptima Policy HH.1101: CalOptima Provider Complaint
M. CalOptima Policy HH.1102: CalOptima Member Complaint
N. CalOptima Policy EE.1101: Additions, Changes and Terminations to CalOptima Providers Information, CalOptima Providers Directory, and Web-based Directory.
I.O. CalOptima Policy MA.1001: Glossary of Terms 9002: Member Grievance Process

VI. REGULATORY APPROVALS

P. 6/1/15: CalOptima Policy MA.9006: Provider Complaint Process

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J.Q.CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

A.R. Department of Health Care Services All Plan Letter 16-001:Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertifications

K. Title 42 United States Code §11101 et seq.

A.S.

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTION

Not Applicable

None to DateA. 06/01/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

A. 6/1/14: GG.1607: Adverse Activity Process
B. 2/1/13: GG.1607: Adverse Activity Process
C. 11/1/11: MA.7009b: Adverse Activity Process
D. 11/1/11: GG.1607: Adverse Activity Process
E. 4/1/07: GG.1607: Credentialing, Adverse Activity Files
F. 3/1/07: MA.7009b: Credentialing, Adverse Activity Files
G. 11/99: GG.1607: Credentialing, Adverse Activity Files
H. 8/98: GG.1607: Credentialing, Adverse Activity Files
12/95: GG.1607: Credentialing, Adverse Activity File

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/1995	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	08/1998	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/1999	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	03/01/2007	MA.7009b	Credentialing, Adverse Activity Files	Medi-Cal
Revised	04/01/2007	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/2011	GG.1607	Adverse Activity Process	Medi-Cal
Revised	11/01/2011	MA.7009b	Adverse Activity Process	OneCare
Revised	02/01/2013	GG.1607	Adverse Activity Process	Medi-Cal OneCare

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Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2014	GG.1607	Adverse Activity Process	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1607Δ	Monitoring Adverse Activities	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Behavioral Health Providers	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Behavioral Health Providers	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
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.
Long Term Support Services (LTSS) Providers	A licensed practitioner such as physicians, NMP's, social workers, and nurse managers
Medical Health Delivery Organizations (HDOs)	Organizations that are contracted to provide medical services such as hospitals, home health agencies, skilled nursing facilities, free standing surgical centers, extended care facilities (LTC), nursing homes (assisted living), hospice, community clinic, urgent care centers, dialysis centers, Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), radiology centers, clinical laboratories, rehabilitation facilities.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner who practices independently under state law, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), Audiologist furnishing covered services.
Physician Practitioner	A licensed 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), furnishing covered services.
Service Health Delivery Organizations (HDOs)	Organizations that are contracted to provide services that support member needs such as ambulance, non-emergency medical transportation, durable medical equipment and providers of other member facing services such as, transportation services, meal services, and homecare services.
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.

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Policy #: GG.1607Δ
Title: **Monitoring Adverse Activities**
Department: Medical Affairs
Section: Quality Improvement

CEO Approval: Michael Schrader _____

Effective Date: 12/95
Last Review Date: 06/01/17
Last Revised Date: 06/01/17

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

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I. PURPOSE

This policy establishes a process for ongoing monitoring of contracted or non-contracted practitioners and Healthcare Delivery Organization's (HDOs) Adverse Activity.

II. POLICY

A. CalOptima shall perform ongoing monitoring of practitioner or HDO sanctions, complaints, and quality issues between Recredentialing cycles.

B. A Health Network shall perform ongoing monitoring of practitioner or HDO sanctions, complaints, and quality issues between Recredentialing cycles that at a minimum, is in accordance with this Policy.

C. CalOptima shall take appropriate action against practitioners or HDOs when the CalOptima Quality Improvement (QI) Department identifies adverse activity.

D. CalOptima shall notify practitioners and HDOs if limiting practice, in writing, within thirty (30) calendar days.

E. Adverse Activities include , but are not limited to the following:

1. Any adverse action by the Medical Board of California, taken or pending, including, but not limited to, an accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter of reprimand, or any formal restriction, probation, suspension, or revocation of licensure, or cease of practice with charges pending;

2. An action taken by a Peer Review Body (as defined in State or Federal law), or other organizations, that results in the filing of a report under Business & Professions Code Sections 805 or 805.01 report with the Medical Board of California and/or a report with the National Practitioner Data Bank (NPDB);

3. A revocation of a Drug Enforcement Agency (DEA) license;

4. A conviction of a felony or misdemeanor of moral turpitude;

5. Any action against a certification under the Medicare or Medicaid programs;

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6. A cancellation, non-renewal, or material reduction in medical liability insurance policy coverage;

7. Any action taken by the California Department of Public Health, Division of Licensing and Certification;

8. Any action taken by the Health and Human Services Office of the Inspector General (OIG);

9. Any action taken by System for Award Management (SAM); or

10. A pattern or trend concerning quality of care issues and complaints that have been identified through the CalOptima Quality Improvement Department.

III. PROCEDURE

A. CalOptima monitors practitioners and HDOs on an ongoing basis to identify Adverse Activities that may affect participation in CalOptima program.

B. CalOptima monitors various State and Federal boards, agencies, and databanks for Adverse Activity(ies) including:

1. OIG exclusion list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

2. SAM list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

3. Business & Professions Code Sections 805 and 805.01, and continuous monitoring NPDB reports;

4. Medicare Opt-Out Physicians: upon Credentialing and Recredentialing and ongoing on a quarterly basis;

5. Medi-Cal Provider Suspended and Ineligible list: upon Credentialing and Recredentialing and ongoing on a monthly basis; and

6. Medical Board of California notifications: as published via e-mail notifications of license suspensions, restrictions, revocations, surrenders and disciplinary actions.

C. CalOptima shall review all information within thirty (30) calendar days of its release.

D. Any adverse activity that limits or removes a practitioner's right to practice will be reported via Provider Alert to the Quality Medical Director for approval. Once approved, the Provider Relations or Health Network Relations Departments will be notified. In addition, Provider Data Management Services (PDMS) will be notified and will enter an alert in Facets™ which will also be captured in Guiding Care for the UM staff's notification.

E. Any adverse activities identified shall be tracked in the adverse activity database.

F. Upon credentialing and recredentialing, adverse activities identified in the tracking database will be summarized and added to the practitioner and HDO file in Credentialing database.

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G. On a bi-monthly basis or earlier, depending on the nature of the adverse activity and CalOptima requirements, the QI Department shall report, in a confidential manner, all findings to the Credentialing Peer Review Committee (CPRC).

H. On a quarterly basis, CalOptima's Grievance & Appeals Resolution Services (GARS) Department shall report to the Quality Improvement Committee (QIC) all complaints, including a summary of data analysis, regarding service, attitude, and access, in accordance with CalOptima Policies CMC.9001: Member Complaint Process, CMC.9002: Member Grievance Process, HH.1102: CalOptima Member Complaint, MA.9002: Member Grievance Process.

I. The QI Department shall forward all Practitioner and HDO potential quality issues received from internal and external sources to a CalOptima Medical Director for review and potential action, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

J. CalOptima shall inform affected practitioners or HDOs of the appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

K. CalOptima's Quality Improvement Department shall maintain Credentialing information in a Credentialing file, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files, and shall ensure that all Credentialing files are up-to-date.

L. All suspensions and terminations from any licensing or regulating agency will be reported through the Regulatory Affairs & Compliance Department to the Department of Health Care Services (DHCS) within ten (10) days of final notification to CalOptima.

   a. The report to DHCS shall include the following:

      i. Contract status (by delegated entity, if applicable) with the named provider.

      ii. The number of beneficiaries receiving services from the provider by all lines of business including any delegated entity, LTSS, or OneCare Connect.

M. Any alert affecting Health Networks will be communicated through the Health Network Relations Department, as applicable.

N. Any alert that may affect provider directories will follow processes outlined in CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-Based Directory.

IV. ATTACHMENTS

A. Ongoing Monitoring Website Information Matrix

V. REFERENCES

A. California Business and Professions Code, §§805 and 805.01
B. California Business and Professions Code, §4022
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

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E. CalOptima PACE Program Agreement
F. CalOptima Policy CMC.9001: Member Complaint Process
G. CalOptima Policy CMC.9002: Member Grievance Process
H. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
I. CalOptima Policy GG.1611: Potential Quality Issue Review Process
J. CalOptima Policy GG.1615: CalOptima Direct Corrective Action Plan for Practitioners
K. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
L. CalOptima Policy HH.1101: CalOptima Provider Complaint
M. CalOptima Policy HH.1102: CalOptima Member Complaint
N. CalOptima Policy EE.1101: Additions, Changes and Terminations to CalOptima Providers Information, CalOptima Providers Directory, and Web-based Directory.
O. CalOptima Policy MA.9002: Member Grievance Process
P. CalOptima Policy MA.9006: Provider Complaint Process
Q. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
R. Department of Health Care Services All Plan Letter 16-001:Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertifications
S. Title 42 United States Code §11101 et seq.

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTION

A. 06/01/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/1995	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	08/1998	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/1999	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	03/01/2007	MA.7009b	Credentialing, Adverse Activity Files	Medi-Cal
Revised	04/01/2007	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/2011	GG.1607	Adverse Activity Process	Medi-Cal
Revised	11/01/2011	MA.7009b	Adverse Activity Process	OneCare
Revised	02/01/2013	GG.1607	Adverse Activity Process	Medi-Cal OneCare
Revised	06/01/2014	GG.1607	Adverse Activity Process	Medi-Cal OneCare OneCare Connect

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Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2017	GG.1607Δ	Monitoring Adverse Activities	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

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Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 PH:(916) 263-2382 or (800) 633-2322 Enforcement Central File Room PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord. (916) 263-2449	MD	**www.mbc.ca.gov** **All communications for disciplinary actions will be done by e-mail to subscribers.** **Link to subscribe for actions:** **http://www.mbc.ca.gov/Subscribers/** **Link for all Disciplinary Actions/License Alerts distributed:** **http://www.mbc.ca.gov/Publications/Disciplinary_Actions/** **Enforcement Public Document Search (Search by Name or Lic:** **http://www2.mbc.ca.gov/PDL/Search.aspx**	You must signup to subscribe for E-mail notifications of accusations, license suspensions, restrictions, revocations, or surrenders for physicians and surgeons licensed by the MBOC. Disciplinary action documents are obtainable via the web-site by: • Link to Enforcement Public Document Search (on the left side of page under check your doctor online) or in the • License verification section; Under Public Documents – Top Right	Bi-Monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final
Osteopathic Medical Board of CA 1300 National Drive, Suite #150 Sacramento, CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax E-mail:osteopathic@dca.ca.gov Enforcement/Disciplines(916)-928-8390 Ext. 6	DO	**www.ombc.ca.gov** **Direct Link To Enforcement Actions:** **http://www.ombc.ca.gov/consumers/enforce_action.shtml** **Subscribe to e-mail Alerts** **http://www.ombc.ca.gov/consumers/enforce_action.shtml**	▪ Link to Consumers Tab at the top ▪ Link to Enforcement Action Can get on a distribution list by e-mailing J. Corey Sparks, Lead Enforcement Analyst E-mail: Corey.Sparks@dca.ca.gov 916-928-8393 (PH) 916-928-8392 (FAX) The board is behind in updating the website. You can subscribe or send an e-mail to get on the distribution list. 01/18/17 – 2nd Quarter 2016 is the last posted report. E-mails distribution is current	Quarterly via the Website E-Mail Distribution list:

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Medical Board of California **Board of Podiatric Medicine** 2005 Evergreen Street, Ste. 1300 Sacramento, CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651 Email: BPM@dca.ca.gov Enforcement Program Central File Room Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 FAX: (916) 263-2420	DPM	**www.bpm.ca.gov** **Direct Link toEnforcement Resources:** **http://www.bpm.ca.gov/consumers/index.shtml** **Subscribers list** **http://www.mbc.ca.gov/Subscribers/** .	▪ Consumers ▪ Link to Enforcement Resources ▪ Link to Recent Disciplinary Actions(Categorized by the following): ➢ Decisions ➢ Accusations Filed ➢ Accusation and Petition to Revoke Probation filed ➢ Accusations and/or Statement of Issues Withdrawn or Dismissed ➢ Statement of Issues Listed alphabetically by category: Decision, Accusation, etc. 9/21/16 was the latest update on 12/15/16 and no reports were available. Updated01/17/17	Board of Podiatric Medicine: Changes to viewing information. On the website go to recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. History not available only current accusations and decisions latest one year from effective date. You can subscribe to actions related to licenses
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento, CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204 Email: acupuncture@dca.ca.gov To order copies of actions send to Attn of Consumer Protection Program	LAC/AC	**www.acupuncture.ca.gov** **Direct Link to Disciplinary Actions:** **www.acupuncture.ca.gov/consumers/board_actions.shtml** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/acupuncture/subscribe.php**	▪ Link to Consumer at the top ▪ Link to DisciplinaryActions Last update January 5, 2017	Monthly running report listed Alpha Newer actions highlighted with date in blue. Note: Board meetings are held quarterly.

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

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Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625 E-Mail: BBSWebmaster@bbs.ca.gov	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	**www.bbs.ca.gov** **Sign up for subscribers list for disciplinary actions.** **https://www.dca.ca.gov/webapps/bbs/subscribe.php**	You must sign up for Subscriber list to obtain Enforcement Actions. E-mail will be sent to you. If you don't sign up as a subscriber, the News Letters will provide disciplinary actions.	**Via Subscriptions Only** Information must be obtained via subscription. For Subscribers: E-mail reports were sent:
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street, Suite 142A Sacramento, CA 95814 PH (916) 263-5355 FAX (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	**www.chiro.ca.gov** **Monthly Reports** **http://www.chiro.ca.gov/enforcement/actions.shtml**	Note monthly disciplinary actions reports ▪ Link to Enforcement at the top right side (next to Contact Us) ▪ Link to Disciplinary Actions ▪ Actions listed by month and year Last report December 2016	Monthly
Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 PH: (916) 263-2300 PH: (877)729-7789 Toll Free Fax #: (916) 263-2140 Email:dentalboard@dca.ca.gov Enforcement Unit PH: 916-274-6326	DDS, DMD	**www.dbc.ca.gov** **Direct Link to Disciplinary Actions:** **http://www.dbc.ca.gov/consumers/hotsheets.shtml**	▪ Link Home Page ▪ Under Highlights at the bottom of the page-Link to Hot Sheet! Dental Disciplinary Action ▪ Actions listed by month and year Or ▪ Link to Consumer ▪ Hot Sheets (Summary of Administrative Actions Last report December 2016	Monthly Note: At the end of the list it provides a date posted. As of 12/31/2016

Revised 01-25-2017
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Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento, CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701 Email: cbot@dca.ca.gov Email: EnfPrg@dca.ca.gov	OT, OTA	**www.bot.ca.gov** **Direct Link To Enforcement Actions:** **http://www.bot.ca.gov/consumers/disciplinary_action.shtml** **Sign up for subscribers list for disciplinary actions: https://www.dca.ca.gov/webapps/bot/subscribe.php**	▪ Link to Consumer at the top ▪ Link to Disciplinary Action Practitioners are listed under: Revocations, Surrenders and Other Disciplinary Orders: A – L and M – Z. **Sign up to receive a monthly Hot Sheet List of disciplinary actions via e-mail to:** EnfPrg.Enfprg@dca.ca.gov Will need to send a written request to obtain the information, which may be sent back to you via e-mail.	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action. E-Mail Submission
California State Board of Optometry 2450 Del Paso Road, Suite 105 Sacramento, CA 95834 PH:(916) 575-7170 Fax (916) 575-7292 Email: optometry@dca.ca.gov	OD	**www.optometry.ca.gov** **Direct Link To Enforcement Actions:** **http://www.optometry.ca.gov/consumers/disciplinary.shtml**	▪ Link to Consumer at the top ▪ Link to Citations and Disciplinary Actions ▪ Bottom of page actions are posted by year Practitioners are listed by year, type of action and then alphabetically Note: Report provides a Last Updated date at the top of the report. Last update12/22/2016	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. Recommend monthly review. The Board typically adopts formal disciplinary actions during regularly scheduled quarterly meetings.

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento, CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	**www.ptb.ca.gov** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/ptbc/interested_parties.php**	Disciplinary action and license reinstatement information may be obtained by checking the Board's online license verification system. Last update 9/28/15	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
Physician AssistantBoard (PAB) 2005 Evergreen Street Suite 1100 Sacramento, CA 95815 PH: (916) 561-8780 FAX(916) 263-2671 Email:pacommittee@mbc.ca.gov	PA/PAC	**www.pac.ca.gov** **Direct Link To Enforcement Actions:** **www.pac.ca.gov/forms_pubs/disciplinaryactions.shtml**	▪ Link to Consumers ▪ Link to Disciplinary Action ▪ Link to Month within the year at bottom of the page Practitioners listed via month, then Alpha Last report listed December 2016	Monthly Note Reports for December 2014 – July 2015 were all posted at the same time, between 8/25/15 and 8/31/15.
Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834 bopmail@dca.ca.gov Office Main Line (916)-574-7720 **Toll Free Number: 1-866-503-3221.**	PhD, PsyD	**www.psychboard.ca.gov** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/psychboard/subscribe.php**	**Monthly reports are no longer available on the website. (change took place around September or October 2014)** You must sign up for Subscriber list to obtain Enforcement Actions. E-mail will be sent to you. If you don't sign up as a subscriber, the News Letters will provide disciplinary actions. To order copies documents, send your written request, including the name and license number of the licensee, to the attention of the Enforcement Program at the Board's offices in Sacramento. A fee is charged for these documents.	**Via Subscriptions Only** Information must be obtained via subscription. For Subscribers: E-mail

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
CA Board of Registered Nursing 1747 North Market Blvd, Suite 150 Sacramento, CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 Phone: (916) 322-3350 FAX (916) 574-7693. Email: enforcement_brn@dca.ca.gov	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse (CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)	**www.rn.ca.gov** **Unlicensed Practice/Nurse Imposter Citations:** **http://www.rn.ca.gov/enforcement/unlicprac.shtml**	Disciplinary action and license reinstatement information may be obtained by checking the Board's online license verification system. Photocopies of this information may be requested by faxing the Board's Enforcement Program at (916) 574-7693. Or You can subscribe to the National Council of State Board of Nursing (BCSBN) Nursys e-Notify system**.** **See website information below.**	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
National Council of State Board of Nursing (BCSBN) 111 East Wacker Drive, Suite 2900 Chicago, IL 60601-4277 Phone:(312) 525-3600 Fax: **(**312) 279-1032 Email: info@ncsbn.org .	Additional information for RN/LVN/NP/CNM	**www.nursys.com** To subscribe for daily, weekly or monthly (depending on how often you want to be updated) updates on license status, expirations and disciplinary actions. **https://www.nursys.com/EN/ENDefault.aspx**	Nursys e-Notify informs you if you employed RNs or LPN/VNs and Advance Practice Nurses (APRN in the categories of Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM) and Clinical Nurse Specialist (CNS) have received public discipline or alerts from their licensing jurisdiction(s).	.
Speech-Language Pathology & Audiology Board 2005 Evergreen Street, Suite 2100 Sacramento, CA 95815 Email: speechandhearing@dca.ca.gov Main Phone Line: (916) 263-2666 Main Fax Line: (916) 263-2668	SP, AU	**http://www.speechandhearing.ca.gov/** **Direct Link to Accusations Pending and Disciplinary Actions:** **http://www.speechandhearing.ca.gov/consumers/enforcement.shtml** As of1/18/2017the information represents disciplinary action taken by the Board from:7/1/07 – 09/30/2016.	▪ Link to Consumer ▪ Link to Enforcement ▪ Link to Accusations pending or Disciplinary Actions 1. For actions pending Board decisions select "SP/AU" For Speech-Language Pathology & Audiology 2. For Board decisions select "Disciplinary Actions". Last report listed FY 2016-2017 Action Taken	**Quarterly** Disciplinary Actions are listed by fiscal year. Pending Actions are listed alphabetically by first name.

Ongoing Monitoring Website Information 01-25-2017

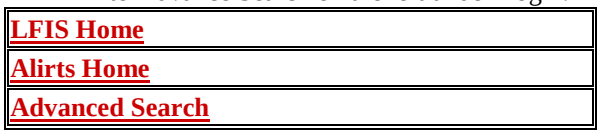
Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments	Report Frequency
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare /Medicaidsanction &exclusions	**www.oig.hhs.gov** **Direct Link for individuals:** **http://exclusions.oig.hhs.gov/** **Direct Link to exclusion database** **http://oig.hhs.gov/exclusions/exclusions_list.asp**	▪ Link to Exclusions ▪ Link to LEIE Downloadable Databases under the Exclusion Program tab ▪ Link to the various reports, exclusions, reinstatements or databases. To subscribe for notifications follow instructions: Get Email updates	**Monthly** (see note under instructions regarding subscribing notifications)
Noridian Healthcare Solutions **Medicare Opt-Out Physicians** **JE MAC** **1855-609-9960 Select Provider Enrollment** **https://med.noridianmedicare.com/web/jeb**	Medicare Opt-Out	**https://www.noridianmedicare.com** Link to JE Part B **https://med.noridianmedicare.com/web/jeb** **Direct Link to Opt-Out Reports:** **https://med.noridianmedicare.com/web/jeb/enrollment/opt-out/opt-out-listing**	Under Medicare Contracts: ▪ Jurisdiction E Part B ▪ Link to Enrollment ▪ Opt Out of Medicare ▪ Opt Out Listing ▪ Link to Opt Out Listing by State: • Excel Listing or • HTML Listing On 01/20/17 Listing as follows: Excel Listing or (Last update 01/19/17) HTML Listing (Last update 01/19/17) However the HTML update noted the incorrect year 1/19/2016. Correction was made on 2/3/2017	**Quarterly** Last update: 01/19/17(updated 1/20/17) 08/15/16 06/13/16 (6/10/16) 12/23/15 10/30/15 Northern 10/08/15 Southern 08/14/15 07/07/15 04/13/15 03/11/15 01/28/15
CMS.gov **Centers for Medicare & Medicaid Services**	Medicare Opt-Out Affidavits	**https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z**	This link will provide information regarding Opt Out Affidavits and Opt Providers from Data.CMS.gov.	

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Ongoing Monitoring Website Information 01-25-2017

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments	Report Frequency
Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	**www.medi-cal.ca.gov** **DirectLink to Suspended and Ineligible Provider List**: **http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp**	From Home Page: ▪ Link to References ▪ Suspended and Ineligible Provider List ▪ Under Download the S&I List is the list for the month. (Bottom of the page) Or ▪ Link to References ▪ Provider Enrollment ▪ Suspended and Ineligible Provider List ▪ Under Download the S&I List is the list for the month. (Bottom of the page) Last published 1/13/17	**Monthly**
SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	**https://www.sam.gov/portal/SAM/#1** SAM Registration **https://uscontractorregistration.com/** Note: The SAM website has a user guide: Link to SAM User Guide- v1.8.3 of 350:	Select Search Records at the top ▪ Under: Advanced Search ▪ Select Advance Search - Exclusion ▪ Select Single Search ▪ Scroll down and enter the Active Date to and from for the month you are reviewing ▪ Click search ▪ Export Results	**Monthly**
DEA Office of Diversion Control **800-882-9539** **deadiversionwebmaster@usdoj.gov**	**DEA Verification**	**www.deadiversion.usdoj.gov/** **Direct Link to Validation Form** **https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp**	On the right side under Links: Link to Registration Validation Need DEA #, Name as it appears on your registration and SSN or TIN provided on application. **Note**: Please does not use the Duplicate Certification Link as it is for Physicians, use the Registration Validation Link.	**NA**

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
The Licensed Facility Information system (LFIS) The Automated Licensing Information and Report Tracking System (ALIRTS) Contains license and utilization data information of healthcare facilities in California. The Licensed Facility Information system (LFIS) is maintained by the Office of Statewide Health Planning and Development to collect and display licensing and other basic information about California's hospitals, long-term care facilities, primary care and specialty clinics, home health agencies and hospices.	**Organizational Providers License Verification:** Hospitals Long-term care facilities Home Health Agencies Hospices Primary care and Specialty clinics	**www.alirts.oshpd.ca.gov/Default.aspx** **Direct Link:** **www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx**	The main source of the information in LFIS is the licenses issued by the Department of Health Services (DHS) Licensing and Certification District Offices. Contact information for these District Offices is available at: www.dhs.ca.gov/LNC/default.htm **To search for a facility** • Enter name in box that is found in top right corner  or • Link to Advance Search on the left under Login.  You may search by using the following four search categories, Facility Name, Facility Number, License and Legal Entity. Enter your search parameters within the one category you selected and click the Search button to the right.
The California Department of Public Health (CDPH) General Information (916) 558-1784	**Organizational Providers License Verification:** Hospitals Surgery Centers Home Health Agencies Hospices Dialysis Centers Others	http://www.cdph.ca.gov/Pages/DEFAULT.aspx Licensed Facility Report http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing Health Facilities Search http://hfcis.cdph.ca.gov/search.aspx	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 800-465-3203 customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an**Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

Revised 01-25-2017
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Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only authorized official distributor of the Death Master file on the web. Final Rule Establishing Certification Program for Access to Death Master File in Effect The National Technical Information Service (NTIS) established a certification program for subscribers to the Limited Access Death Master File (LADMF) through a Final Rule (FR), pursuant to Section 203 of the Bipartisan Budget Act of 2013 (Pub. L. 113-67) which also requires NTIS to recoup the cost of the certification program through processing fees. The FR was published in the Federal Register Wednesday, June 1, 2016, and became effective Monday, November 28, 2016. The FR may be reviewed at **https://www.gpo.gov/fdsys/pkg/FR-2016-06-01/html/2016-12479.htm**.	**Subscription to the Limited Access Death Master File (LADMF)**	**Social Security Death Master File (DMF) Website** https://www.ssdmf.com/FolderID/1/SessionID/%7B17B93F37-71E0-433B-B3F2-B9BA03D721A6%7D/PageVars/Library/InfoManage/Guide.htm **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	You must register to obtain information and there are several fees associated with the service.

Additional Websites

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses **- American Academy of Nurse Practitioners Certification Board (AANPCB) (1/2017)** **(Formerly the American Academy of Nurse Practitioners Certification Program (AANPCP)** **- American Nurses Credentialing Center** (ANCC) **- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties**(ncc) **- Pediatric Nursing Certification Board** (PNCB) **- American Association of Critical-Care Nurses** (AACN)	NP	AANPCB - www.aanpcert.org/ ANCC -**www.nursecredentialing.org** ncc - **www.nccwebsite.org** PNCB - **www.pncb.org** AACN -**www.aacn.org**	Informational only to verify board certification	**Board Certification**
National Commission on Certification of PA's (NCCPA)	PAC	**http://www.nccpa.net/**	Informational only to verify board certification	**Board Certification**
American Midwifery Certification Board (amcb) 849 International Drive, Suite 120 Linthicum, MD 21090 Phone 410-694-9424	CNM and CM	**http://www.amcbmidwife.org/**	Under the Verify AMCB Certification ▪ Click Search button ▪ Enter last Name, First Name and Certification Number ▪ Click Search Button	**Board Certification** Informational only to verify board certification needed

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Additional Websites

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill, NC 27516 Phone 919-537-8031 email: office@abpp.org	PhD, PsyD	**http://www.abpp.org/**	Under Find a Board Certified Psychologists ▪ Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed
Three specialty certifying boards are currently approved under California law for DPMs: – **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA)). – **The American Board of Podiatric Medicine**(Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine – **American Board of Multiple Specialties in Podiatry.** (Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	• American Board of Foot and Ankle Surgery. https://www.abfas.org/ • The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ • American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**

Policy #:	GG.1633Δ
Title:	**Board Certification Requirements for Physicians**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/08
Last Review Date:	~~8/1/15~~06/01/17
Last Revised Date:	~~8/1/15~~06/01/17

Applicable to:

- ~~▪~~
- Medi-Cal
- ~~▪~~
- OneCare
- ~~▪~~
- OneCare Connect
- ☒ PACE
- ~~▪~~

I. PURPOSE

~~To describe~~This policy describes CalOptima's requirement for Board Certification of contracted physicians.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Credentialing~~	~~The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.~~
~~Health Network (HN)~~	~~A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Provider Group.~~
~~Physician Medical Group (PMG)~~	~~A California professional medical corporation that employs or has entered into contracts with physicians who are licensed to practice medicine in the State of California that has entered into contract with CalOptima to arrange for the provision of Covered Services to Members assigned to that Provider Group.~~

~~III.~~II. POLICY

A. A contracted physician shall be ~~Board Certified~~board certified within five (5) years following the date upon which that contracted physician completes his or her residency~~.~~, with the exception of any contracted physician whose board certification time requirement is shorter or longer than the foregoing in which case such shorter or longer period shall apply. For example, a contracted podiatric physician shall be board certified within seven (7) years following the date upon which that contracted podiatric physician completes his or her residency.~~.~~

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B. A ~~contracted~~ physician ~~who is~~may be grandfathered and exempt from the requirements of this Policy if all of the following apply:

a. The physician was first licensed to practice medicine in a United States jurisdiction before January 1, 2008~~,~~; and

b. The physician was a contracted physician with CalOptima or a Health Network prior to July 1, 2016; and

c. The physician's contract with CalOptima or the Health Network did not lapse or terminate for any reason.

~~B.~~C. If a physician's contract with CalOptima or a Health Network lapsed or terminated for any reason, as set forth in Section II.B.~~iii~~ above, then the physician is considered a new physician and is ~~exempt from the requirements of this policy.~~not grandfathered for board certification purposes. In these cases, the physician must apply for a new contract and credentialed status and must meet all the requirements of CalOptima Policy GG.1643: Minimum Physician Standards, including without limitation, the board certification requirement.

~~C.~~D. Except as provided in Section ~~IV~~II.B. of this ~~policy~~Policy, a contracted physician who is required to be board certified shall, at all times, maintain ~~Board Certification~~that status in order to participate in ~~the~~ CalOptima ~~program.~~ programs.

~~D.~~E. A contracted physician shall meet Credentialing and Recredentialing requirements, in accordance with CalOptima Policy GG.~~1609Δ~~1650Δ: Credentialing and Recredentialing.

~~—~~A Health Network shall establish policies and procedures for Board Certification of contracted physicians that, at minimum, meet and verify compliance with the requirements as outlined in this Policy.

F.

~~IV.~~III. PROCEDURE

A. A contracted physician shall indicate his or her Board Certification status as part of the Credentialing and Recredentialing process.

B. ~~CalOptima, a Health Network (HN) or a Physician Medical Group (PMG)~~CalOptima shall independently verify that a contracted physician is either currently Board Certified, or exempt from the Board Certification requirements of this policy.

C. If, ~~upon Recredentialing~~at any time, CalOptima~~, a HN or PMG~~ finds that a contracted physician has failed to maintain his or her ~~Board Certification~~board certification as required by this ~~policy~~Policy, CalOptima~~, the HN or PMG~~ shall notify the contracted physician of his or her noncompliance with the requirements of this ~~policy~~Policy and shall require the contracted physician to ~~re-establish Board Certification~~demonstrate within ~~six (6) months~~thirty (30) calendar days after receipt of notice from CalOptima~~, the HN or PMG.~~ that he or she is actually board certified.

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D. If the contracted physician fails to ~~re-establish his or her Board Certification~~demonstrate within ~~six (6) months~~thirty (30) calendar days after receipt of notice from CalOptima~~, HN or PMG,~~ that he or she is board certified as required by this Policy, then CalOptima ~~shall remove such contracted physician from participation~~will terminate the contract within sixty (60) calendar days and upon appropriate notice to members, provide notice to the contracted physician that he or she is no longer eligible to participate in ~~the~~ CalOptima ~~program~~programs, and ~~shall~~ reassign any affected ~~Members.~~ members.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

A. CalOptima Policy AA.1100: Glossary of Terms
B. CalOptima Policy CMC.1001: Glossary of Terms
C. CalOptima Policy GG.1609Δ: Credentialing and Recredentialing
D. CalOptima Policy GG.1643: Minimum Physician Standards
~~D.~~ CalOptima Policy MA.1001: Glossary of ~~Terms~~
E. ~~CalOptima Policy CMC.1001: Glossary of Terms~~
F. ~~CalOptima~~Terms
~~F.~~G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. NCQA Standards and Guidelines

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ~~ACTION~~ACTIONS

A. 06/01/17: Regular Meeting of the CalOptima Board of Directors
B. ~~8/7~~08/07~~: /07:~~ Regular Meeting of the CalOptima Board of Directors
C. ~~6/5~~06/05/07: Regular Meeting of the CalOptima Board of Directors

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	~~Version~~ Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	01/01/2008	GG.1633	Board Certification Requirements for Physicians	Medi-Cal
~~Revision Date 1~~Revised	03/01/2013	GG.1633	Board Certification Requirements for Physicians	Medi-Cal

DRAFT

Version	~~Version~~ Date	Policy Number	Policy Title	Line(s) of Business
~~Revision Date 2~~Revised	08/01/2015	GG.1633Δ	Board Certification Requirements for Physicians	Medi-Cal OneCare OneCare Connect PACE
Revised	06/01/2017	GG.1633Δ	Board Certification Requirements for Physicians	Medi-Cal OneCare OneCare Connect PACE

DRAFT

IX. GLOSSARY

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

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Policy #:	GG.1633Δ
Title:	**Board Certification Requirements for Physicians**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/08
Last Review Date:	06/01/17
Last Revised Date:	06/01/17
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

DRAFT

I. PURPOSE

This policy describes CalOptima's requirement for Board Certification of contracted physicians.

II. POLICY

A. A contracted physician shall be board certified within five (5) years following the date upon which that contracted physician completes his or her residency, with the exception of any contracted physician whose board certification time requirement is shorter or longer than the foregoing in which case such shorter or longer period shall apply. For example, a contracted podiatric physician shall be board certified within seven (7) years following the date upon which that contracted podiatric physician completes his or her residency.

B. A physician may be grandfathered and exempt from the requirements of this Policy if all of the following apply:

   a. The physician was first licensed to practice medicine in a United States jurisdiction before January 1, 2008; and

   b. The physician was a contracted physician with CalOptima or a Health Network prior to July 1, 2016; and

   c. The physician's contract with CalOptima or the Health Network did not lapse or terminate for any reason.

C. If a physician's contract with CalOptima or a Health Network lapsed or terminated for any reason, as set forth in Section II.B. above, then the physician is considered a new physician and is not grandfathered for board certification purposes. In these cases, the physician must apply for a new contract and credentialed status and must meet all the requirements of CalOptima Policy GG.1643: Minimum Physician Standards, including without limitation, the board certification requirement.

D. Except as provided in Section II.B. of this Policy, a contracted physician who is required to be board certified shall, at all times, maintain that status in order to participate in CalOptima programs.

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E. A contracted physician shall meet Credentialing and Recredentialing requirements, in accordance with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing.

F. A Health Network shall establish policies and procedures for Board Certification of contracted physicians that, at minimum, meet and verify compliance with the requirements as outlined in this Policy.

III. PROCEDURE

A. A contracted physician shall indicate his or her Board Certification status as part of the Credentialing and Recredentialing process.

B. CalOptima shall independently verify that a contracted physician is either currently Board Certified, or exempt from the Board Certification requirements of this policy.

C. If, at any time, CalOptima finds that a contracted physician has failed to maintain his or her board certification as required by this Policy, CalOptima shall notify the contracted physician of his or her noncompliance with the requirements of this Policy and shall require the contracted physician to demonstrate within thirty (30) calendar days after receipt of notice from CalOptima that he or she is actually board certified.

D. If the contracted physician fails to demonstrate within thirty (30) calendar days after receipt of notice from CalOptima that he or she is board certified as required by this Policy, then CalOptima will terminate the contract within sixty (60) calendar days and upon appropriate notice to members, provide notice to the contracted physician that he or she is no longer eligible to participate in CalOptima programs, and reassign any affected members.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Policy AA.1100: Glossary of Terms
B. CalOptima Policy CMC.1001: Glossary of Terms
C. CalOptima Policy GG.1609Δ: Credentialing and Recredentialing
D. CalOptima Policy GG.1643: Minimum Physician Standards
E. CalOptima Policy MA.1001: Glossary of Terms
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. NCQA Standards and Guidelines

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 06/01/17: Regular Meeting of the CalOptima Board of Directors
B. 08/07/07: Regular Meeting of the CalOptima Board of Directors

DRAFT

C. 06/05/07: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2008	GG.1633	Board Certification Requirements for Physicians	Medi-Cal
Revised	03/01/2013	GG.1633	Board Certification Requirements for Physicians	Medi-Cal
Revised	08/01/2015	GG.1633Δ	Board Certification Requirements for Physicians	Medi-Cal OneCare OneCare Connect PACE
Revised	06/01/2017	GG.1633Δ	Board Certification Requirements for Physicians	Medi-Cal OneCare OneCare Connect PACE

DRAFT

IX. GLOSSARY

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

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Policy #:	GG.1609Δ
Title:	**Credentialing and Recredentialing**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader
Effective Date:	10/95
Last Review Date:	03/01/15
Last Revised Date:	03/01/15

This policy shall apply to the following CalOptima line of business (LOB):

- Medi-Cal
- OneCare
- OneCare Connect (Effective 7/1/15)
- PACE

TO BE RETIRED BY GG.1650 & GG.1651

I. PURPOSE

To define the process by which CalOptima, a Health Network or Physician Medical Group (PMG) shall evaluate and select a Practitioner or Healthcare Delivery Organization (HDO) for participation in CalOptima.

II. DEFINITIONS

Term	Definition
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Full Scope Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.
Healthcare Delivery Organization (HDO)	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Skilled Nursing Facility (SNF)	Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR,

	Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program.

III. POLICY

A. CalOptima shall establish guidelines by which CalOptima and its Health Networks and PMGs shall evaluate and select Practitioners and HDOs to participate in CalOptima, in accordance with Title 42, Code of Federal Regulations, section 422.04(a).

B. The CalOptima Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing a Practitioner's or HDO's Credentialing information and determining such Practitioner's or HDO's participation in CalOptima.

C. CalOptima shall require Credentialing and Recredentialing of all of the following Practitioners and HDOs contracted with CalOptima:

1. Medical Practitioners, such as a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Dentist and Oral Surgeon

2. A Behavioral Health Provider which includes:

   a. Psychiatrist and other physicians;

   b. Addiction medicine specialist;

   c. Doctoral and master's-level psychologists who are State of California certified or licensed;

   d. Master's-level clinical social workers who are State of California certified or licensed;

   e. Master's-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or State of California certified or licensed; and

   f. Other Behavioral Healthcare specialists that are licensed, certified or registered by the State of California to practice independently;

3. HDOs, which include, but are not limited to:

   a. An acute care hospital;

   b. Home health agency;

   c. Freestanding ambulatory surgi-center;

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d. Skilled Nursing Facility; and

e. Community Based Adult Services (CBAS) Centers.

4. Mid-Level Practitioners, which include, but are not limited to: a Certified Nurse Mid-Wife (CNM), Nurse Practitioner (NP), Physician Assistant (PA), Optometrist (OPT), and Registered Nurse Practitioner (RNP), who provides Covered Services to a Member, in accordance with CalOptima Policy GG.1606: Credentialing and Recredentialing of Mid-Level Practitioners.

D. CalOptima may not require Credentialing and Recredentialing for:

1. Practitioners that practice exclusively within the inpatient setting (e.g., Hospitalist) and provides care for a Member only as a result of the Member being directed to the hospital or inpatient setting;

2. Practitioners that practice exclusively within freestanding facilities, and provides care for a Member only as a result of the Member being directed to the facility;

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima delegates utilization management (UM) functions;

4. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with CalOptima;

5. Practitioners that do not provide care for a Member in a treatment setting (e.g., Board-Certified consultant); and

6. A rental network Practitioner that is specifically for out-of-care services, and there are no incentives communicated to Members; Members have no obligation to seek care from rental network practitioners, and may see out-of-area practitioner.

E. CalOptima shall not add a Practitioner or HDO to the CalOptima network until such Practitioner or HDO has completed the Credentialing process, unless CalOptima determines it is in the best interest of the Member for the Practitioner to render care.

1. CalOptima may offer Provisional Credential Status to a Practitioner for a duration not to exceed sixty (60) calendar days in accordance with Section IV.B.1 of this policy.

F. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network or PMG, in accordance with CalOptima Policy GG.1605Δ: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Health Network or a PMG shall apply the participation guidelines set forth in this policy equally to its Contracted Practitioners and Providers.

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2. A Health Network or PMG shall submit a monthly report to CalOptima of its Credentialed and Recredentialed Practitioners. A Physician Hospital Consortium (PHC) will include all HDOs credentialed and recredentialed.

G. CalOptima, a Health Network or PMG shall Recredential a Practitioner or HDO every three (3) years.

H. CalOptima, Health Network or PMG shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in between Credentialing cycles and shall provide evidence of monthly review of the Medical Board of California Hot Sheet and Office of Inspector General (OIG) exclusion or suspension list.

I. On a monthly basis, CalOptima shall monitor the Medicare/Medi-Cal Sanction List. CalOptima shall immediately suspend any Practitioner or HDO identified on the Sanction List.

J. On a quarterly basis, CalOptima shall monitor the Northern and Southern California published list of Medicare Opt-Out Report from the Centers for Medicare & Medicaid Services (CMS). The report must be reviewed within thirty (30) calendar days of its release as part of the on-going monitoring process.

K. If CalOptima declines to include a Practitioner or an HDO in CalOptima, the plan shall notify such Practitioner or HDO in writing of the reason for its decision, in accordance with CalOptima Policy GG1616: Fair Hearing Plan for Practitioners and as described in California Participating Physician Application (CPPA) Addendum – Notice to Practitioners of Credentialing Rights and Responsibilities.

L. CalOptima shall not discriminate, in terms of participation, reimbursement, or indemnification, against any Practitioner who is acting within the scope of his or her license, certification, or registration under federal and state law, solely on the basis of the license or certification. This prohibition shall not preclude CalOptima from:

1. Refusing to grant participation to a Practitioner in excess of the number necessary to meet the needs of Members;

2. Using different reimbursement amounts for different specialties or for different Practitioners in the same specialty; and

3. Implementing measures designed to maintain quality and control costs consistent with CalOptima's responsibilities.

M. CalOptima, a Health Network or PMG shall not discriminate against a Practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

N. CalOptima, a Health Network or PMG shall not make or decline Credentialing and Recredentialing decisions based solely on a Practitioner's race, ethnicity or national identity, gender, age, sexual orientation, or the type of procedure or patient in which the Practitioner specializes.

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O. CalOptima shall monitor and prevent discriminatory Credentialing decisions as follows:

1. Periodic audits of Credentialing files (in-process, denied, and approved files) to ensure Practitioners are not discriminated against;

2. Periodic audits of Practitioner Complaints to determine if there are complaints alleging Discrimination. (The CPRC reviews quarterly reports for all Complaints, including Discrimination);

3. Maintain a heterogeneous Credentialing committee membership; and

4. Uphold the requirement of those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate when making decisions.

P. CalOptima shall maintain the Confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

IV. PROCEDURE

A. Peer Review Body

1. CalOptima, a Health Network or PMG shall designate a Peer Review Body (PRB) that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Such PRB shall include representation from a range of Practitioners, a majority of whom shall be peers of the Practitioner or Applicant, and shall be responsible for reviewing a Practitioner's Credentialing and Recredentialing files, and determining the Practitioner's participation in CalOptima.

3. The Chief Medical Officer (CMO) or his or her designee shall deem a Practitioner's Credentialing or Recredentialing file, clean and approved, upon meeting the clean file review process.

a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no professional review actions or malpractice claims (pending or settled) within the last five (5) years from the date of the Credentialing or Recredentialing review.

b. A clean file shall be considered approved, and effective on the date that the CMO or his or her designee review and approve a Practitioner's Credentialing or Recredentialing file, and deem the file clean.

i. An approved list of clean files shall be presented at the CPRC to be reflected in the meeting minutes.

c. Files that do not meet the clean file review process include, but are not limited to:

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i. Malpractice claims; or

ii. OIG or National Practitioner Data Bank (NPDB) report, with information on the report or health status that may limit or enable a Practitioner to perform his or her specific duties.

d. Files that do not meet the credentialing criteria shall be presented to the CPRC for review and determination to accept, limit, restrict, or deny the application.

e. The CPRC meeting minutes shall reflect any discussion and determination or approval of file(s).

4. The PRB shall make recommendations, shall be based on the Practitioners' ability to deliver care based on the Credentialing information collected from the clean file review process, and shall be verified prior to making a Credentialing decision.

a. The QI Department shall send Practitioner or applicant a decision letter, along with Appeal right's information, to include, but not be limited to:

i. Acceptance;

ii. Acceptance with restrictions;

iii. Conditional acceptance; or

iv. Denial of the application, with a letter of explanation forwarded to the applicant.

5. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:

a. Monitoring:

i. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that Practitioners are not discriminated against; and

ii. Review Practitioner Complaints to determine if there are Complaints alleging discrimination.

iii. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality of care issues for complaints alleging discrimination, and will report outcomes to the CPRC for review and determination.

b. Preventing:

i. The QI Department shall maintain a heterogeneous Credentialing committee, and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

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B. Practitioner Credentialing

1. CalOptima may assign provisional Credential Status for the duration of sixty (60) calendar days while CalOptima undertakes the full Credentialing process. CalOptima shall require primary source verification of the following for provisional Credential status, as applicable:

    a. Current license to practice;

    b. Current and valid DEA certificate;

    c. Current malpractice insurance that meets minimal requirements, and review of past five (5) years history;

    d. Query of NPDB, OIG, and Medi-Cal Sanctions and Investigations;

        i. Cumulative Medi-Cal suspension/ineligibility.

    e. Currently Credentialed by a participating Health Network or PMG with an open panel;

    f. Complete and current Full Scope Facility Site Review (FSR), with a passing score of 80% or better, for PCPs and high volume obstetrics and gynecologist;

    g. Profile Sheet on file from affiliated Health Network or PMG;

    h. Completion of the full scope Credentialing application and attestations; and

    i. A Practitioner may only be provisionally Credentialed once.

2. A Practitioner shall submit a completed, signed, and dated Credentialing application to CalOptima, a Health Network or PMG that includes a current and signed attestation regarding:

    a. Any work history gap that exceeds six (6) months, including written clarification;

    b. The essential functions of the position that the Practitioner cannot perform, with or without accommodation (i.e., health status);

    c. Lack of present illegal drug use that impairs current ability to practice;

    d. History of any loss of license or limitations on licensure or privileges;

    e. History of any loss or limitation of privileges or disciplinary activity;

    f. Current malpractice insurance coverage;

    g. The correctness and completeness of the application; and

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h. Current Full Scope FSR with a passing score within last three (3) years.

3. A Practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

4. Upon receipt of a complete Credentialing application, CalOptima or a Health Network or PMG shall verify the following:

a. A current, valid California license to practice in effect at the time of the PRB's decision;

b. Current attestation, including an HIV specialist attestation, if applicable;

c. Current professional liability (malpractice) insurance or self-insurance (e.g., trust, escrow accounts coverage) in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the PRB's decision;

d. Written or verbal confirmation from the Practitioner's primary inpatient admitting facility that the Practitioner has privileges in good standing, or confirmation that the Practitioner refers patients to hospital-based Practitioners (Hospitalist);

e. No exclusion, suspension, or ineligibility to participate in any state and federal health care program at the time of the PRB's decision;

f. Active enrollment status with Medi-Cal;

i. The CMO or his or her designee has the ability to make exceptions in regards to Medi-Cal enrollment status in order to satisfy access and continuity of care requirements;

ii. The CMO or his or her designee may also make exceptions to Providers outside of Orange, Los Angeles, San Bernardino, Riverside and San Diego Counties, on a case-by-case basis

g. The QI Department shall review all complaints filed against a Practitioner.

h. No exclusion from participation at any time in federal or state health care programs based on conduct within the last ten (10) years that supports a mandatory exclusion under the Medicare program, as set forth in Title 42, United States Code, Sections 1320.7(a), as follows:

i. A conviction of a criminal offense related to the delivery of an item or service under federal or state health care programs;

ii. A felony conviction related to neglect or abuse of patients in connection with the delivery of a health care item or service;

iii. A felony conviction related to health care fraud; or

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iv. A felony conviction related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

i. A valid DEA or Controlled Dangerous Substances (CDS) certificate, if applicable, in effect at the time of the Credentialing decision;

j. Education and training, including Board Certification if the Practitioner states on the application that he or she is Board Certified;

k. Work history including all activity since completion of training (on initial Credentialing) and any change since last Recredentialing. The Practitioner shall provide, in writing, an explanation of any gaps of six (6) months or more;

l. Status of clinical privileges at a CalOptima contracted hospital designated by the Practitioner, as applicable. Practitioner may be part of a Health Network or PMG that utilizes an admitting panel, or may have coverage arrangements with other Practitioners that have been credentialed by the Health Network or PMG. Any alternative admitting arrangements must be documented in the Credentialing file;

m. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the Practitioner; and

n. A valid National Practitioner Identifier (NPI) number.

5. CalOptima, a Health Network or PMG shall verify the information provided through primary or secondary source verification using industry-recognized verification sources or a credentials verification organization. This information includes, but is not limited to:

a. Current license to practice;

b. Education and training, including evidence of graduation from an appropriate professional school, and, if applicable, completion of residency, and specialty training;

c. Board Certification;

d. Clinical privilege in a hospital, as designated by the Practitioner, verified by contacting the facility and obtaining a copy of the Practitioner directory;

e. A copy of current malpractice insurance certificate;

f. Valid DEA or CDS certification, obtained through confirmation by National Technical Information Service (NTIS); and

g. History of professional liability claims, information about sanction or limitation of licensure, or information about eligibility for the Medicare program, obtained through the NPDB and the Health Integrity Protection Databank, and OIG.

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6. CalOptima, a Health Network or PMG shall provide the applicant with notification of the Credentialing decision within sixty (60) calendar days after the date of the PRB's decision.

7. CalOptima, a Health Network or PMG shall render a final decision within one hundred eighty (180) calendar days from the date of the signature attestation.

8. If CalOptima, a Health Network or PMG is unable to render a decision within one hundred eighty (180) calendar days after receipt of the application for any Practitioner, the Practitioner's Credentialing or Recredentialing application shall be considered expired.

9. CalOptima shall reassign any Members assigned to a Practitioner with Provisional Credential status whose application is expired, after sixty (60) calendar days, to another physician pursuant to CalOptima's contract with the Department of Health Care Services (DHCS).

C. Practitioner Recredentialing

1. CalOptima, a Health Network or PMG shall Recredential a Practitioner every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima, a Health Network, or PMG shall:

   a. Collect and verify, at a minimum, all of the information required for initial Credentialing, as set forth in Section III.C of this policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the Practitioner; and

   b. Incorporate the following data in the decision-making process:

      i. Member Complaints, grievances, and Appeals, including number and type during the past three (3) years;

      ii. Information from quality review activities;

      iii. Utilization management (UM) information;

      iv. Member satisfaction;

      v. Medical Record reviews;

      vi. FSR results; and

      vii. Compliance with the terms of the Practitioner's contract.

D. CalOptima shall conduct on-site reviews of a Practitioner in the Credentialing and Recredentialing process, in accordance with CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

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E. CalOptima, a Health Network or PMG shall ensure that a Practitioner has current California licensure, DEA certificate (if applicable), and malpractice insurance at all times during such Practitioner's participation in CalOptima.

F. Practitioner Rights

1. New applicants for Credentialing will receive Practitioner Rights attached to the California Participating Practitioner Application (CPPA) as Addendum A, describing the following:

a. Right to review information

i. Practitioners will be notified of their right to review information CalOptima has obtained to evaluate their Credentialing application, attestation, or curriculum vitae.

b. Right to correct erroneous information

i. All Practitioners will be notified by certified mail when Credentialing information obtained from other sources varies substantially from that provided by the Practitioner;

ii. All Practitioners have the right to correct erroneous information, as follows:

a) The Practitioner has forty-eight (48) hours from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by certified mail with a detailed explanation regarding erroneous information, as well as copy(ies) of corrected information; and

c) All submissions will be mailed to CalOptima's Quality Improvement (QI) Department using the following address:

Attention: Quality Improvement Department – Credentialing

CalOptima
505 City Parkway West
Orange, CA 92868

iii. CalOptima is not required to reveal the source of information, if the information is not obtained to meet CalOptima's Credentialing verification requirements or if law prohibits Disclosure.

3. Documentation of receipt of Corrections

a. A Practitioner shall be notified via a letter to document CalOptima's receipt of the identified erroneous information.

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4. Right to be notified of application status

    a. Practitioners will be notified of their right to be informed of the status of their application.

    b. Practitioners can contact the Credentialing Department by phone, e-mail or facsimile requesting the status of their application. The QI Department will respond within one (1) business day of the status of the Practitioner's application.

G. Healthcare Delivery Organization (HDO) Credentialing and Recredentialing

1. Before contracting with an HDO, and every three (3) years after executing a contract, CalOptima shall ensure that the HDO is in good standing with state and federal licensing and regulatory bodies, and that the HDO has been reviewed and approved by an accrediting body. If the HDO has not been approved by an accrediting body, evidence of a DHCS site review must be presented, or performance of an FSR must be completed. If the HDO fails to meet the above mentioned criteria, CalOptima will not Credential the HDO.

2. CalOptima shall ensure that an HDO:

    a. Has active Medi-Cal enrollment status;

    b. Is licensed to operate in the state, and is in compliance with any other applicable state or federal requirement;

    c. Is reviewed and approved by an appropriate accrediting body, or meets the standards established by CalOptima. Accrediting bodies include, but are not limited to:

        i. Joint Commission;

        ii. Accreditation Association for Ambulatory Health Care (AAAHC);

        iii. Commission on Accreditation of Rehabilitation Facilities (CARF);

        iv. Community Health Accreditation Program (CHAP);

        v. Continuing Care Accreditation Commission (CCAC); and

        vi. Clinical Laboratory Improvement Amendments (CLIA);

    d. Maintains current liability (malpractice) insurance of at least the minimum amounts required by the Contract for Health Care Services, which are:

        i. General liability at one million ($1,000,000) per occurrences and three million ($3,000,000) aggregate;

        ii. Professional liability at one million ($1,000,000) per occurrences and three million ($3,000,000) aggregate;

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iii. Non- facilities liability at one million ($1,000,000) per occurrence and two million ($2,000,000) aggregate; and

iv. Professional liability at one million ($1,000,000) per occurrence and three million ($3,000,000) aggregate.

3. A hospital shall submit the following documentation:

   a. A copy of the certificate of accreditation by the Joint Commission or another CMS-deemed accreditation organization;

   b. A copy of its current California Department of Public Health (DPH) license;

   c. A copy of its Medicare certificate and a copy of the Medicare exemptions, if any; and

   d. A current certificate of insurance.

4. A home health care Provider, Skilled Nursing Facility (including an intermediate, sub-acute, or extended care facility), free-standing surgical center, stand alone urgent care center, portable x-ray supplier, radiology facility, laboratory facility, and dialysis facility (a Provider of end-stage renal disease services), hospice, comprehensive outpatient rehabilitation facility (CORF), outpatient physical therapy and speech therapy provider, ambulatory surgery center (ASC), and Provider of outpatient diabetes self-management shall submit the following documentation:

   a. A copy of its current California license;

   b. An applicable accreditation or on-site review or certification by CMS or DHCS;

      i. If the site is not accredited or certified by CMS or DHCS, an FSR shall be performed. The facility shall not be Credentialed, if an FSR is not performed.

   c. A laboratory facility shall submit a CMS issued CLIA certificate, or a hospital based exemption from CLIA;

   d. A copy of its Medicare certificate;

   e. A copy of DHP license or most recent DHP audit report; and

   f. A current certificate of insurance.

5. A Durable Medical Equipment (DME) vendor shall submit the following documentation to CalOptima, a Health Network or PMG (CalOptima and Health Networks are not required to Credential or Recredential DME vendors):

   a. A copy of its California business license;

   b. A copy of its Medicare certificate; and

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c. A current certificate of insurance.

6. A CBAS Center shall submit the following documentation to CalOptima to ensure compliance with Title 22 of the California Code of Regulations: :

a. Copy of State and City license;

b. California Department of Aging (CDA) Survey results along with Corrective Action Plan and Approval letter from CDA;

c. Copy of Biohazard Contract;

d. Copy of Staff license and certification;

e. Trained staff CPR certification;

f. A copy of current certificates of insurances;

g. A copy of equipment calibration logs; and

h. Copy of attendance sign in sheet for CBAS training of all staff.

7. Miscellaneous service vendor

a. A copy of its California business license;

b. A current certificate of insurance;

c. A copy of all staff certifications or licensure;

d. A copy of equipment calibration logs; and

e. A copy of accreditation or certification.

8. Except as provided in CalOptima Policy GG1608Δ: Full Scope Site Reviews, CalOptima does not delegate the FSR and Medical Record Review (MRR) processes to a Health Network or PMG. CalOptima assumes all authority, responsibility, and coordination of FSRs and MRRs, and reports its findings to Health Networks or PMGs to incorporate the documents to support review prior to Credentialing decisions.

H. CalOptima, a Health Network or PMG shall maintain Credentialing files that include documentation of required elements, as described in this policy.

I. A Health Network or PMG shall submit the following reports to CalOptima:

1. On a monthly basis, a report of Credentialed and Recredentialed Practitioners, and any adverse decisions taken by the peer review committee;

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2. On an annual basis, a report documenting the Health Network's or PMG's evaluation process of any sub-delegated agency; and

3. Upon CalOptima's request, a report that lists all Practitioners with current licensure, DEA certification, Board Certification status, and malpractice information.

J. CalOptima shall conduct Credentialing oversight audits of a Health Network or PMG, in accordance with CalOptima Policy GG.1619: Health Network Delegation Oversight.

V. ATTACHMENTS

A. California Participating Physician Application (CPPA)
B. Verification Matrix

VI. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Care Services
C. Title 42, Code of Federal Regulations, Section 422.04(a)
D. Title 42, Code of Federal Regulations, Section 422.205
E. Title 42, United States Code, Section 1320.7(a)
F. California Business and Professions Code, Section 805
G. California Evidence Code, Section 1157
H. Title XVIII and XIV of the Social Security Act
I. CalOptima Policy AA.1000: Glossary of Terms
J. CalOptima Policy GG.1605Δ: Delegation and Oversight of Credentialing and Recredentialing
K. CalOptima Policy GG.1606: Credentialing and Recredentialing of Mid-Level Practitioners
L. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
M. CalOptima Policy GG.1619: Health Network Delegation Oversight
N. 2014 NCQA Standards and Guidelines
O. MMCD Policy Letter 02-03: Credentialing and Recredentialing: Timeline Change, New Primary Source Verification Requirements, and Verification of Credentials of Non-Physician Medical Practitioners
P. OneCare MA.1001: Glossary of Terms

VII. REGULATORY APPROVALS

04/28/15: Department of Health Care Services

VIII. BOARD ACTION

Not Applicable

IX. REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	10/1995	GG.1609	Health Network Practitioner Credentialing Program

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Version	Version Date	Policy Number	Policy Title
			Standards
Revision Date 1	12/1995	GG.1609	Health Network Practitioner Credentialing Program Standards
Revision Date 2	12/1996	GG.1609	Health Network Practitioner Credentialing Program Standards
Revision Date 3	02/1998	GG.1609	Health Network Practitioner Credentialing Program Standards
Revision Date 4	01/1999	GG.1609	Credentialing and Recredentialing
Revision Date 5	08/2000	GG.1609	Credentialing and Recredentialing
Revision Date 6	02/2001	GG.1609	Credentialing and Recredentialing
Revision Date 7	01/01/2006	MA.7009	Credentialing and Recredentialing
Revision Date 8	07/01/2007	GG.1609	Credentialing and Recredentialing
Revision Date 9	07/01/2009	GG.1609	Credentialing and Recredentialing
Revision Date 10	09/01/2011	GG.1609	Credentialing and Recredentialing
Revision Date 11	03/01/2012	MA.7009	Credentialing and Recredentialing
Revision Date 12	02/01/2013	GG.1609	Credentialing and Recredentialing
Review Date 1	06/01/2014	GG.1609	Credentialing and Recredentialing
Revision Date 13	02/01/2015	MA.1609	Credentialing and Recredentialing
Revision Date 14	03/01/2015	GG.1609Δ	Credentialing and Recredentialing

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Policy #:	GG.1606Δ
Title:	**Credentialing and Recredentialing of Mid-Level Practitioners**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	12/95
Last Review Date:	8/1/15
Last Revised Date:	8/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- Medi-Cal
- OneCare
- OneCare Connect
- PACE

TO BE REFERRED BY GG.1650

I. PURPOSE

To establish a process for ensuring that Mid-Level Practitioners who participate in CalOptima have the necessary credentials and supervision to perform their functions.

II. DEFINITIONS

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Mid-level Practitioner	A non-physician practitioner who has a professional license and certification. They include, but are not limited to, a Registered Nurse Practitioner (RNP), Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Physician Assistant (PA), Certified Registered Nurse Anesthetist (CRNA), Optometrist, Acupuncturist, Licensed Clinical Social Worker (LCSW), or Chiropractor.
Physician Medical Group	A California professional medical corporation that employs or has entered into contracts with physicians who are licensed to practice medicine in the State of California that has entered into a contract with CalOptima to arrange for the provision of Covered Services to Members assigned to that Provider Group.

III. POLICY

A. CalOptima or a delegated Health Network and Physician Medical Group (PMG) shall Credential and Recredential all Mid-Level Practitioners, in accordance with this policy.

B. A Mid-Level Practitioner shall be credentialed appropriately under the supervision of a practicing Practitioner who has executed a signed Delegation Services Agreement with the Mid-Level Practitioner.

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IV. PROCEDURE

A. Credentialing

1. All Mid-Level Practitioners shall have a valid, current license or certificate issued by the State of California. Copies of current licenses and certificates of agreements with supervising physicians must be kept in the Credentialing files.

   a. Nurse Practitioners and Nurse Midwives shall be certified, in accordance with the requirements of the Board of Registered Nursing (BRN) and applicable regulations of the BRN.

   b. Physician Assistants shall be licensed, in accordance with the requirements of the Physician Assistant Examiners Committee and the Medical Board of California.

2. Mid-Level Practitioners shall maintain skills in their field of practice by participating in continuing medical education programs, following the guidelines of the Physician Assistant, Nurse Practitioner, and Certified Nurse Midwife certification process. The supervising physician shall monitor this process.

3. Mid-Level Practitioners shall maintain their Advanced Cardiopulmonary Life Support certification.

B. Supervision

1. All Mid-Level Practitioners shall practice under the supervision of a licensed physician, either directly or through the use of medical policies and procedures (e.g., protocols established by the Practitioner according to the category of Practitioner).

2. A Practitioner who supervises a Mid-Level Practitioner shall be Credentialed, in accordance with the CalOptima Policy GG.1609Δ: Credentialing and Recredentialing.

3. A supervising Practitioner shall submit, to each Health Network in which he or she participates, copies of the licenses for all Mid-Level Practitioners employed by him or her, and verification that his or her liability insurance covers the Mid-Level Practitioner, or verification that the Mid-Level Practitioner has his or her own coverage.

4. A supervising Practitioner shall review and co-sign all charts involving care provided by a Mid-Level Practitioner within thirty (30) days after the date the care was given.

5. A supervising Practitioner shall review and co-sign all charts involving care provided by a Physician Assistant within thirty (30) days after a medication has been ordered.

6. A supervising Practitioner shall review and co-sign all charts involving care provided by a Physician Assistant within thirty (30) days after a medication has been prescribed, administered, or dispensed, and/or the Physician Assistant transmits a Schedule II drug order.

7. The supervising Practitioner must be available for consultation with the Mid-Level Practitioner at all times when the Mid-Level Practitioner is providing services, either by physical presence, by telephone, or by electronic communication.

TO BE RETIRED BY GG.1650

8. A supervising Practitioner is responsible for a Mid-Level Practitioner at all times, and may authorize and approve a Mid-Level Practitioner to perform primary care services, pursuant to the CalOptima Policy GG.1602Δ: Mid-Level Practitioner Scope of Practice.

9. The number of non-physician medical Practitioners who may be supervised by a single Primary Care Practitioner (PCP) shall be limited to the full-time equivalent of one (1) of the following:

   a. Four (4) Nurse Practitioners;

   b. Three (3) Nurse Midwives;

   c. Two (2) Physician Assistants; or

   d. Four (4) of the above individuals in any combination that does not exceed the limit stated in either (b) or (c) above.

10. A Mid-Level Practitioner may participate in the after-hours call network, provided that the supervising Practitioner is also available for consultation at all times during which the Mid-Level Practitioner is on call.

C. Recredentialing/Site Review

1. The Recredentialing process for Mid-Level Practitioner shall be repeated every three (3) years.

2. At the time of the on-site facility audit, documents requested for review by CalOptima's Certified Site Reviewers shall include the signed agreement between the Practitioner and the Mid-Level Practitioner, and the Supervising Practitioner certificate, if a Physician Assistant is employed.

V. ATTACHMENTS

A. California Participating Practitioner Application

VI. REFERENCES

A. CalOptima Policy AA.1100: Glossary of Terms
B. CalOptima Policy GG.1602Δ: Mid-Level Practitioner Scope of Practice
C. CalOptima Policy GG.1609Δ: Credentialing and Recredentialing
D. CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners
E. California Business and Professions Code, Section 805
F. California Evidence Code, Section 1157
G. Title 42, Code of Federal Regulations, Section 422.04(a)
H. Title 42, Code of Federal Regulations, Section 422.205
I. Title 42, United States Code, Section 1320-7(a)
J. CalOptima Policy MA.1001: Glossary of Terms
K. CalOptima Policy CMC.1001: Glossary of Terms
L. CalOptima Three-Way Contract with CMS and DHCS for Cal MediConnect

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

TO BE RETIRED BY GG.1650

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	12/1995	GG.1606	Credentialing and Recredentialing of Mid-Level Practitioners
Revision Date 1	03/1999	GG.1606	Credentialing and Recredentialing of Mid-Level Practitioners
Revision Date 2	11/1999	GG.1606	Credentialing and Recredentialing of Mid-Level Practitioners
Revision Date 3	04/01/2007	GG.1606	Credentialing and Recredentialing of Mid-Level Practitioners
Revision Date 4	03/01/2013	GG.1606	Credentialing and Recredentialing of Mid-Level Practitioners
Revision Date 5	08/01/2015	GG.1606	Credentialing and Recredentialing of Mid-Level Practitioners

TO BE RETIRED BY GG.1650

Policy:	GG.1657Δ
Title:	**Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	03/07/2019
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

For 20200604 BOD Review Only

I. PURPOSE

The Medical Board of California (Medical Board) and the National Practitioner Data Bank (NPDB) have imposed legal requirements for reporting certain actions related to the credentialing and peer review processes. This policy is to comply with the Medical Board and the NPDB requirements for reporting adverse actions against a CalOptima Practitioner.

II. POLICY

A. CalOptima and its delegated Health Networks shall comply with Medical Board and NPDB requirements for reporting certain actions related to CalOptima Practitioner credentialing and peer review activities.

B. If a reportable action is taken by CalOptima against a Practitioner, then CalOptima is the entity responsible for making the report(s) required by this Policy unless such reports are not required by applicable law.

C. Health Networks shall have policies and procedures that address credentialing and peer review reporting requirements. If a reportable action is taken by a Health Network against a Practitioner, then the Health Network is the entity responsible to make the report(s) unless such reports are not required by applicable law.

1. If a reportable action is taken by a Health Network, the Health Network shall report the reportable action, via mail or electronically, to the CalOptima Quality Improvement Department Director within thirty (30) calendar days from the date the action was reported.

III. PROCEDURE

A. Reports to the Medical Board Based on Business and Professions Code § 805

1. Entity Required to Report

Back to Agenda Back to Item

a. Only one peer review body is required to file an 805 Report for a Practitioner's Medical or Disciplinary Cause or Reason. If another peer review entity reports a Practitioner, CalOptima is not required to file a separate 805 Report attributable to the same conduct by the Practitioner.

2. Actions Requiring Reports

a. An 805 Report is filed with the Medical Board whenever any of the following actions become final:

i. Denial of a Practitioner's application for CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

ii. Non-renewal of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

iii. Restriction on a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

iv. Termination of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason; or

v. Restriction on a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a Medical or Disciplinary Cause or Reason;

vi. Imposition of summary suspension of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason if the summary suspension remains in effect for more than fourteen (14) calendar days.

b. An 805 Report is filed with the Medical Board if the Practitioner takes any of the following actions listed below:

i. Resignation or leave of absence by a Practitioner from CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason;

ii. Withdrawal or abandonment of a Practitioner's application for CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or

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Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason; or

iii. Withdrawal or abandonment of a Practitioner's request for renewal of CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason.

3. Timeframe for filing an 805 Report

a. Denial, Non-Renewal, Restriction or Termination

i. CalOptima shall file an 805 Report within fifteen (15) calendar days after the conclusion of all of the proceedings under CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, if a denial, non-renewal, restriction or termination results from such proceedings;

ii. CalOptima shall file an 805 Report within fifteen (15) calendar days if the Practitioner's participation is restricted for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a Medical or Disciplinary Cause or Reason.

b. Summary Suspension

i. CalOptima shall file an 805 Report within fifteen (15) calendar days following the imposition of summary suspension, if the summary suspension remains in effect for a period in excess of fourteen (14) consecutive days.

a) CalOptima will also file an additional 805 Report with the Medical Board about the same Practitioner following conclusion of all proceedings under CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, or after the effective date of resignation or leave of absence by a Practitioner related to such summary suspension/investigation, within the timeframes provided in Section III.A.3.a.i. and Section III.A.3.c.i.

c. Resignation, Withdrawal or Leave of Absence

i. CalOptima shall file an 805 Report within fifteen (15) calendar days after the effective date of resignation or leave of absence by a Practitioner.

4. Exhaustion of Fair Hearing Rights

a. For any action taken by CalOptima pursuant to Section III.A.2.a.i. through Section III.A.2.a.iv., CalOptima shall not file an 805 Report until the Practitioner has had the opportunity to either waive or exhaust his/her Fair Hearing rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

5. Notification to the Practitioner

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a. CalOptima shall provide the Practitioner with a copy of the 805 Report and notice advising the Practitioner of his/her right to submit additional statements or other information, electronically or otherwise to the Medical Board and that information submitted electronically will be disclosed to those who request it, pursuant to Section 800(c) of the Business and Professions Code.

6. Additional Reporting Requirements

a. If the Practitioner is an osteopathic physician, dentist or psychologist, CalOptima shall also file a copy of the 805 Report with the Practitioner's respective Board (e.g. Osteopathic Medical Board of California, Dental Board of California, California Board of Psychology.)

B. Reports to the Medical Board Based on Business and Professions Code §-805.01

1. Actions Requiring Reports

a. An 805.01 Report is filed with the Medical Board whenever a peer review body (e.g. the Credentialing and Peer Review Committee) makes a final decision or recommendation, as specified in Section III.A.2.a.i. through Section III.A.2.a.iv. above, resulting in a final proposed action to be taken against a Practitioner based on the peer review body's determination, following formal investigation of Practitioner, that any of the acts listed below, may have occurred:

i. Incompetence, gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a matter as to be dangerous or injurious to any person or the public;

ii. The use of, or prescribing for or administering to himself/herself, any controlled substance; or use of any dangerous drug, as defined in Business and Professions Code Section 4022, or of alcoholic beverages, that is dangerous or injurious to the Practitioner, any other person, or the public, or to the extent that such use impairs the ~~**Practitioner's**~~ ability of the Practitioner to practice safely ~~is impaired by use~~;

iii. Repeated acts ~~if~~of clearly excessive prescribing, furnishing, or administering of controlled substances or related acts of prescribing, dispensing or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason therefore (note that in no event shall a Practitioner who is lawfully treating intractable pain be reported for excessive prescribing); or

iv. Sexual misconduct with one or more patients during a course of treatment or examination.

2. Timeframe for filing an 805.01 Report

a. CalOptima shall file an 805.01 Report within fifteen (15) calendar days after a final decision or recommendation regarding disciplinary action based upon a formal

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investigation that concludes that based on an allegation that any of the acts listed in Section III.B.1. of this Policy have occurred.

3. Fair Hearing Rights

   a. CalOptima shall file an 805.01 Report (distinct from an 805 Report) regardless of whether the Practitioner is afforded his/her Fair Hearing Rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

4. Notification to the Practitioner

   a. CalOptima shall provide the Practitioner with a copy of the 805.01 report and notice advising the Practitioner of his/her right to submit additional statements or other information, electronically or otherwise to the Medical Board and that information submitted electronically will be disclosed to those who request it, pursuant to Section 800(c) of the Business and Professions Code.

C. Reports to the National Practitioner Data Bank

1. Actions Requiring Reports

   a. An NPDB Report is filed whenever any of the following actions become final:

      i. An adverse Clinical Privileges action that is based on the Practitioner's professional competence or professional conduct which adversely affects or could adversely affect the health or welfare of a patient when that action adversely affects the Practitioner's authority to provide care to CalOptima patients for more than thirty (30) calendar days. This includes actions taken against a Practitioner's privileges including reducing, restricting, suspending, revoking, denying or not renewing privileges;

      ii. Acceptance of the Practitioner's surrender of Clinical Privileges, or any restriction of such privileges by a Practitioner:

         a) While the Practitioner is under investigation relating to possible incompetence or improper professional conduct; or

         b) In return for not conducting such an investigation or proceeding.

      iii. Withdrawal of an initial application by Practitioner for Clinical Privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action;

      iv. Practitioner does not apply for renewal of Clinical Privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action; or

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v. Summary suspension imposed for more than thirty (30) days based on the Practitioner's professional competence or professional conduct of the Practitioner that adversely ~~effects~~affects, or could adversely affect the health and welfare of a patient and is the result of a professional review action.

2. Timeframe for filing an NPDB Report

a. CalOptima shall file an NPDB Report within thirty (30) calendar days from the date the adverse action was taken or authority to provide care to CalOptima patients is voluntarily surrendered.

3. Fair Hearing Rights

a. Except in the event of a summary suspension in effect less than thirty-one (31) consecutive days or a surrender or restriction of authority to provide care to CalOptima patients, CalOptima shall file a NPDB Report after the Practitioner has had the opportunity to either waive or exhaust his/her fair hearing rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

4. Notification to the Practitioner

a. The NPDB will mail a copy of the submitted report to the Practitioner named in the report. The Practitioner will have the opportunity to review the report for accuracy, and may add a statement to the report, or may dispute the report directly with the NPDB.

5. Additional Reports

a. CalOptima shall file a Revision-to-Action report to supplement an initial report to the NPDB if the summary suspension of a Practitioner is modified or revised as part of CalOptima's final decision in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

D. Persons at CalOptima Required to Report

1. Reports to the Medical Board Based on Business and Professions Code § 805

a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.A.2. of this Policy, the Chief Medical Officer or Physician Designee who participates on CPRC, shall file an 805 Report with the Medical Board in the appropriate time required in Section III.A.3. of this Policy.

2. Reports to the Medical Board Based on Business and Professions Code § 805.01

a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.B.2. of this Policy, the Chief Medical Officer or Physician Designee who participates on CPRC, shall file an 805.01 Report with the Medical Board in the appropriate time required in Section III.B.3. of this Policy.

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3. Reports to the National Practitioner Data Bank

   a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.C.2. of this Policy, Quality Improvement Credentialing Supervisor, shall file a report with the NPDB in the appropriate time required in Section III.C.3. of this Policy.

IV. ATTACHMENTS

~~A.~~ Not Applicable~~Sample 805 Report~~
~~B. Sample 805.01 Report~~
~~C. Sample NPDB Report~~

V. REFERENCES

~~A. California Welfare and Institutions Code, § 14087.58(b)~~
~~B. California Business and Professions Code, §§ 805, 805.01 and 809~~
~~California Health and Safety Code § 1370~~
~~C.~~A. CalOptima Contract for Health Care Services
~~D.~~B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~E.~~C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~F.~~D. CalOptima PACE Program Agreement
~~G.A. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners~~
~~H.~~E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
F. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
G. California Welfare and Institutions Code, §14087.58(b)
H. California Business and Professions Code, §§805, 805.01 and 809
I. California Health and Safety Code §1370
~~I.~~J. Health Care Quality Improvement Act of 1986 (HCQIA), 42 U.S.C. §11101 *et seq.*
~~J.~~K. National Practitioner Data Bank ~~regulations~~Regulations, 45 CFR, Part 60
~~K.~~L. National Practitioner Data Bank ~~2015~~ Guidebook (2018 Edition)
~~L.~~M. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing ~~(2018) CR:7, Element A, Factor 2~~ Standards
~~M.~~ Medical Board of California 805, 805.1: https://www.mbc.ca.gov/Download/Forms/enf-805.pdf & ~~https://www.mbc.ca.gov/Download/Forms/enf-805-01.pdf~~https://www.mbc.ca.gov/Download/Forms/enf-805-01.pdf
~~N.~~
O. National Practitioner Data Bank: ~~https://www.mbc.ca.gov/Download/Forms/enf-805-01.pdfhttps://www.npdb.hrsa.gov/~~https://www.npdb.hrsa.gov/

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

For 20200604 BOD Review Only

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/07/2019	GG.1657Δ	Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting	Med-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1657Δ	Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting	Med-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Clinical Privileges	As provided in the NPDB Guidebook, Clinical Privileges are privileges, and other circumstances (e.g. network participation and panel membership) in which a physician, dentist, or other health care Practitioner is permitted to furnish medical care by a health care entity.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Health Network	A Physician Hospital Consortium (PHC), physician ~~medical~~ group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Practitioner	For purposes of this Policy, Practitioner means a "Licentiate" as that term is defined in Business and Professions Code Section 805 and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168. Practitioner also means an individual who is licensed or otherwise authorized by a State to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized as that term is defined in the Health Care Quality Improvement Act of 1986 (HCQIA) and its implementing regulations.

For 20200604 POD Review Only

Policy:	GG.1657Δ
Title:	**Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	03/07/2019
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

For 20200604 BOD Review Only

I. PURPOSE

The Medical Board of California (Medical Board) and the National Practitioner Data Bank (NPDB) have imposed legal requirements for reporting certain actions related to the credentialing and peer review processes. This policy is to comply with the Medical Board and the NPDB requirements for reporting adverse actions against a CalOptima Practitioner.

II. POLICY

A. CalOptima and its delegated Health Networks shall comply with Medical Board and NPDB requirements for reporting certain actions related to CalOptima Practitioner credentialing and peer review activities.

B. If a reportable action is taken by CalOptima against a Practitioner, then CalOptima is the entity responsible for making the report(s) required by this Policy unless such reports are not required by applicable law.

C. Health Networks shall have policies and procedures that address credentialing and peer review reporting requirements. If a reportable action is taken by a Health Network against a Practitioner, then the Health Network is the entity responsible to make the report(s) unless such reports are not required by applicable law.

1. If a reportable action is taken by a Health Network, the Health Network shall report the reportable action, via mail or electronically, to the CalOptima Quality Improvement Department Director within thirty (30) calendar days from the date the action was reported.

III. PROCEDURE

A. Reports to the Medical Board Based on Business and Professions Code § 805

1. Entity Required to Report

Back to Agenda Back to Item

a. Only one peer review body is required to file an 805 Report for a Practitioner's Medical or Disciplinary Cause or Reason. If another peer review entity reports a Practitioner, CalOptima is not required to file a separate 805 Report attributable to the same conduct by the Practitioner.

2. Actions Requiring Reports

a. An 805 Report is filed with the Medical Board whenever any of the following actions become final:

i. Denial of a Practitioner's application for CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

ii. Non-renewal of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

iii. Restriction on a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

iv. Termination of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason; or

v. Restriction on a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a Medical or Disciplinary Cause or Reason;

vi. Imposition of summary suspension of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason if the summary suspension remains in effect for more than fourteen (14) calendar days.

b. An 805 Report is filed with the Medical Board if the Practitioner takes any of the following actions listed below:

i. Resignation or leave of absence by a Practitioner from CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason;

ii. Withdrawal or abandonment of a Practitioner's application for CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or

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Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason; or

iii. Withdrawal or abandonment of a Practitioner's request for renewal of CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason.

3. Timeframe for filing an 805 Report

a. Denial, Non-Renewal, Restriction or Termination

i. CalOptima shall file an 805 Report within fifteen (15) calendar days after the conclusion of all of the proceedings under CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, if a denial, non-renewal, restriction or termination results from such proceedings;

ii. CalOptima shall file an 805 Report within fifteen (15) calendar days if the Practitioner's participation is restricted for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a Medical or Disciplinary Cause or Reason.

b. Summary Suspension

i. CalOptima shall file an 805 Report within fifteen (15) calendar days following the imposition of summary suspension, if the summary suspension remains in effect for a period in excess of fourteen (14) consecutive days.

a) CalOptima will also file an additional 805 Report with the Medical Board about the same Practitioner following conclusion of all proceedings under CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, or after the effective date of resignation or leave of absence by a Practitioner related to such summary suspension/investigation, within the timeframes provided in Section III.A.3.a.i. and Section III.A.3.c.i.

c. Resignation, Withdrawal or Leave of Absence

i. CalOptima shall file an 805 Report within fifteen (15) calendar days after the effective date of resignation or leave of absence by a Practitioner.

4. Exhaustion of Fair Hearing Rights

a. For any action taken by CalOptima pursuant to Section III.A.2.a.i. through Section III.A.2.a.iv., CalOptima shall not file an 805 Report until the Practitioner has had the opportunity to either waive or exhaust his/her Fair Hearing rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

5. Notification to the Practitioner

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a. CalOptima shall provide the Practitioner with a copy of the 805 Report and notice advising the Practitioner of his/her right to submit additional statements or other information, electronically or otherwise to the Medical Board and that information submitted electronically will be disclosed to those who request it, pursuant to Section 800(c) of the Business and Professions Code.

6. Additional Reporting Requirements

a. If the Practitioner is an osteopathic physician, dentist or psychologist, CalOptima shall also file a copy of the 805 Report with the Practitioner's respective Board (e.g. Osteopathic Medical Board of California, Dental Board of California, California Board of Psychology.)

B. Reports to the Medical Board Based on Business and Professions Code §805.01

1. Actions Requiring Reports

a. An 805.01 Report is filed with the Medical Board whenever a peer review body (e.g. the Credentialing and Peer Review Committee) makes a final decision or recommendation, as specified in Section III.A.2.a.i. through Section III.A.2.a.iv. above, resulting in a final proposed action to be taken against a Practitioner based on the peer review body's determination, following formal investigation of Practitioner, that any of the acts listed below, may have occurred:

i. Incompetence, gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a matter as to be dangerous or injurious to any person or the public;

ii. The use of, or prescribing for or administering to himself/herself, any controlled substance; or use of any dangerous drug, as defined in Business and Professions Code Section 4022, or of alcoholic beverages, that is dangerous or injurious to the Practitioner, any other person, or the public, or to the extent that such use impairs the ability of the Practitioner to practice safely;

iii. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or related acts of prescribing, dispensing or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason therefore (note that in no event shall a Practitioner who is lawfully treating intractable pain be reported for excessive prescribing); or

iv. Sexual misconduct with one or more patients during a course of treatment or examination.

2. Timeframe for filing an 805.01 Report

a. CalOptima shall file an 805.01 Report within fifteen (15) calendar days after a final decision or recommendation regarding disciplinary action based upon a formal

For 20200604 BOD Review Only

investigation that concludes that based on an allegation that any of the acts listed in Section III.B.1. of this Policy have occurred.

3. Fair Hearing Rights

   a. CalOptima shall file an 805.01 Report (distinct from an 805 Report) regardless of whether the Practitioner is afforded his/her Fair Hearing Rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

4. Notification to the Practitioner

   a. CalOptima shall provide the Practitioner with a copy of the 805.01 report and notice advising the Practitioner of his/her right to submit additional statements or other information, electronically or otherwise to the Medical Board and that information submitted electronically will be disclosed to those who request it, pursuant to Section 800(c) of the Business and Professions Code.

C. Reports to the National Practitioner Data Bank

1. Actions Requiring Reports

   a. An NPDB Report is filed whenever any of the following actions become final:

      i. An adverse Clinical Privileges action that is based on the Practitioner's professional competence or professional conduct which adversely affects or could adversely affect the health or welfare of a patient when that action adversely affects the Practitioner's authority to provide care to CalOptima patients for more than thirty (30) calendar days. This includes actions taken against a Practitioner's privileges including reducing, restricting, suspending, revoking, denying or not renewing privileges;

      ii. Acceptance of the Practitioner's surrender of Clinical Privileges, or any restriction of such privileges by a Practitioner:

         a) While the Practitioner is under investigation relating to possible incompetence or improper professional conduct; or

         b) In return for not conducting such an investigation or proceeding.

      iii. Withdrawal of an initial application by Practitioner for Clinical Privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action;

      iv. Practitioner does not apply for renewal of Clinical Privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action; or

For 20200604 BOD Review Only

v. Summary suspension imposed for more than thirty (30) days based on the Practitioner's professional competence or professional conduct of the Practitioner that adversely affects, or could adversely affect the health and welfare of a patient and is the result of a professional review action.

2. Timeframe for filing an NPDB Report

a. CalOptima shall file an NPDB Report within thirty (30) calendar days from the date the adverse action was taken or authority to provide care to CalOptima patients is voluntarily surrendered.

3. Fair Hearing Rights

a. Except in the event of a summary suspension in effect less than thirty-one (31) consecutive days or a surrender or restriction of authority to provide care to CalOptima patients, CalOptima shall file a NPDB Report after the Practitioner has had the opportunity to either waive or exhaust his/her fair hearing rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

4. Notification to the Practitioner

a. The NPDB will mail a copy of the submitted report to the Practitioner named in the report. The Practitioner will have the opportunity to review the report for accuracy, and may add a statement to the report, or may dispute the report directly with the NPDB.

5. Additional Reports

a. CalOptima shall file a Revision-to-Action report to supplement an initial report to the NPDB if the summary suspension of a Practitioner is modified or revised as part of CalOptima's final decision in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

D. Persons at CalOptima Required to Report

1. Reports to the Medical Board Based on Business and Professions Code § 805

a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.A.2. of this Policy, the Chief Medical Officer or Physician Designee who participates on CPRC, shall file an 805 Report with the Medical Board in the appropriate time required in Section III.A.3. of this Policy.

2. Reports to the Medical Board Based on Business and Professions Code § 805.01

a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.B.2. of this Policy, the Chief Medical Officer or Physician Designee who participates on CPRC, shall file an 805.01 Report with the Medical Board in the appropriate time required in Section III.B.3. of this Policy.

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3. Reports to the National Practitioner Data Bank

   a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.C.2. of this Policy, Quality Improvement Credentialing Supervisor, shall file a report with the NPDB in the appropriate time required in Section III.C.3. of this Policy.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
F. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
G. California Welfare and Institutions Code, §14087.58(b)
H. California Business and Professions Code, §§805, 805.01 and 809
I. California Health and Safety Code §1370
J. Health Care Quality Improvement Act of 1986 (HCQIA), 42 U.S.C. §11101 *et seq.*
K. National Practitioner Data Bank Regulations, 45 CFR, Part 60
L. National Practitioner Data Bank Guidebook (2018 Edition)
M. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing Standards
N. Medical Board of California 805, 805.1: https://www.mbc.ca.gov/Download/Forms/enf-805.pdf & https://www.mbc.ca.gov/Download/Forms/enf-805-01.pdf
O. National Practitioner Data Bank: https://www.npdb.hrsa.gov/

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/07/2019	GG.1657Δ	Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting	Med-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	TBD	GG.1657Δ	Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting	Med-Cal OneCare OneCare Connect PACE

1

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IX. GLOSSARY

Term	Definition
Clinical Privileges	As provided in the NPDB Guidebook, Clinical Privileges are privileges, and other circumstances (e.g. network participation and panel membership) in which a physician, dentist, or other health care Practitioner is permitted to furnish medical care by a health care entity.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Practitioner	For purposes of this Policy, Practitioner means a "Licentiate" as that term is defined in Business and Professions Code Section 805 and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168. Practitioner also means an individual who is licensed or otherwise authorized by a State to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized as that term is defined in the Health Care Quality Improvement Act of 1986 (HCQIA) and its implementing regulations.

For 20200604 POD Review Only

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Consider Approval of Policy GG.1657, the Medical Board of California and the National Practitioner Data Bank Reporting Policy

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality Analytics & Population Health Management, (714) 246-8400

Recommended Actions

Recommend approval of Policy GG.1657, Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting.

Background/Discussion

The Medical Board of California (Medical Board) and the National Practitioner Data Bank (NPDB) have imposed legal requirements for reporting certain actions related to the credentialing and peer review processes. This policy has been developed to comply with the Medical Board and the NPDB requirements for reporting adverse actions against a CalOptima Practitioner.

Fiscal Impact

There is no anticipated fiscal impact to the recommended action.

Concurrence

Gary Crockett, Chief Counsel

Attachments

GG.1657: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting

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

2/27/2019 — **Date**

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Policy #:	GG.1657ΔPP
Title:	**Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	TBD
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

The Medical Board of California (Medical Board) and the National Practitioner Data Bank (NPDB) have imposed legal requirements for reporting certain actions related to the credentialing and peer review processes. This policy is to comply with the Medical Board and the NPDB requirements for reporting adverse actions against a CalOptima Practitioner.

II. POLICY

A. CalOptima and its delegated Health Networks shall comply with Medical Board and NPDB requirements for reporting certain actions related to CalOptima Practitioner credentialing and peer review activities.

B. If a reportable action is taken by CalOptima against a Practitioner, then CalOptima is the entity responsible for making the report(s) required by this Policy unless such reports are not required by applicable law.

C. Health Networks shall have policies and procedures that address credentialing and peer review reporting requirements. If a reportable action is taken by a Health Network against a Practitioner, then the Health Network is the entity responsible to make the report(s) unless such reports are not required by applicable law.

1. If a reportable action is taken by a Health Network, the Health Network shall report the reportable action, via mail or electronically, to the CalOptima Quality Improvement Department Director within thirty (30) calendar days from the date the action was reported.

III. PROCEDURE

A. Reports to the Medical Board Based on Business and Professions Code § 805

1. Entity Required to Report

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a. Only one peer review body is required to file an 805 Report for a Practitioner's Medical or Disciplinary Cause or Reason. If another peer review entity reports a Practitioner, CalOptima is not required to file a separate 805 Report attributable to the same conduct by the Practitioner.

2. Actions Requiring Reports

a. An 805 Report is filed with the Medical Board whenever any of the following actions become final:

i. Denial of a Practitioner's application for CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

ii. Non-renewal of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

iii. Restriction on a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

iv. Termination of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason; or

v. Restriction on a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a Medical or Disciplinary Cause or Reason;

vi. Imposition of summary suspension of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason if the summary suspension remains in effect for more than fourteen (14) calendar days.

b. An 805 Report is filed with the Medical Board if the Practitioner takes any of the following actions listed below:

i. Resignation or leave of absence by a Practitioner from CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason;

ii. Withdrawal or abandonment of a Practitioner's application for CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or

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Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason; or

iii. Withdrawal or abandonment of a Practitioner's request for renewal of CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason.

3. Timeframe for filing an 805 Report

a. Denial, Non-Renewal, Restriction or Termination

i. CalOptima shall file an 805 Report within fifteen (15) calendar days after the conclusion of all of the proceedings under CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, if a denial, non-renewal, restriction or termination results from such proceedings;

ii. CalOptima shall file an 805 Report within fifteen (15) calendar days if the Practitioner's participation is restricted for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a Medical or Disciplinary Cause or Reason.

b. Summary Suspension

i. CalOptima shall file an 805 Report within fifteen (15) calendar days following the imposition of summary suspension, if the summary suspension remains in effect for a period in excess of fourteen (14) consecutive days.

a) CalOptima will also file an additional 805 Report with the Medical Board about the same Practitioner following conclusion of all proceedings under CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, or after the effective date of resignation or leave of absence by a Practitioner related to such summary suspension/investigation, within the timeframes provided in Section III.A.3.a.i. and Section III.A.3.c.i.

c. Resignation, Withdrawal or Leave of Absence

i. CalOptima shall file an 805 Report within fifteen (15) calendar days after the effective date of resignation or leave of absence by a Practitioner.

4. Exhaustion of Fair Hearing Rights

a. For any action taken by CalOptima pursuant to Section III.A.2.a.i. through Section III.A.2.a.iv., CalOptima shall not file an 805 Report until the Practitioner has had the opportunity to either waive or exhaust his/her Fair Hearing rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

5. Notification to the Practitioner

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a. CalOptima shall provide the Practitioner with a copy of the 805 Report and notice advising the Practitioner of his/her right to submit additional statements or other information, electronically or otherwise to the Medical Board and that information submitted electronically will be disclosed to those who request it, pursuant to Section 800(c) of the Business and Professions Code.

6. Additional Reporting Requirements

a. If the Practitioner is an osteopathic physician, dentist or psychologist, CalOptima shall also file a copy of the 805 Report with the Practitioner's respective Board (e.g. Osteopathic Medical Board of California, Dental Board of California, California Board of Psychology.)

B. Reports to the Medical Board Based on Business and Professions Code § 805.01

1. Actions Requiring Reports

a. An 805.01 Report is filed with the Medical Board whenever a peer review body (e.g. the Credentialing and Peer Review Committee) makes a final decision or recommendation, as specified in Section III.A.2.a.i. through Section III.A.2.a.iv. above, resulting in a final proposed action to be taken against a Practitioner based on the peer review body's determination, following formal investigation of Practitioner, that any of the acts listed below, may have occurred:

i. Incompetence, gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a matter as to be dangerous or injurious to any person or the public;

ii. The use of, or prescribing for or administering to himself/herself, any controlled substance; or use of any dangerous drug, as defined in Business and Professions Code Section 4022, or of alcoholic beverages, that is dangerous or injurious to the Practitioner, any other person, public, or that the Practitioner's ability to practice safely is impaired by use;

iii. Repeated acts if clearly excessive prescribing, furnishing, or administering of controlled substances or related acts of prescribing, dispensing or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason therefore (note that in no event shall a Practitioner who is lawfully treating intractable pain be reported for excessive prescribing); or

iv. Sexual misconduct with one or more patients during a course of treatment or examination.

2. Timeframe for filing an 805.01 Report

a. CalOptima shall file an 805.01 Report within fifteen (15) calendar days after a final decision or recommendation regarding disciplinary action based upon a formal

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investigation that concludes that based on an allegation that any of the acts listed in Section III.B.1. of this Policy have occurred.

3. Fair Hearing Rights

a. CalOptima shall file an 805.01 Report (distinct from an 805 Report) regardless of whether the Practitioner is afforded his/her Fair Hearing Rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

4. Notification to the Practitioner

a. CalOptima shall provide the Practitioner with a copy of the 805.01 report and notice advising the Practitioner of his/her right to submit additional statements or other information, electronically or otherwise to the Medical Board and that information submitted electronically will be disclosed to those who request it, pursuant to Section 800(c) of the Business and Professions Code.

C. Reports to the National Practitioner Data Bank

1. Actions Requiring Reports

a. An NPDB Report is filed whenever any of the following actions become final:

i. An adverse Clinical Privileges action that is based on the Practitioner's professional competence or professional conduct which adversely affects or could adversely affect the health or welfare of a patient when that action adversely affects the Practitioner's authority to provide care to CalOptima patients for more than thirty (30) calendar days. This includes actions taken against a Practitioner's privileges including reducing, restricting, suspending, revoking, denying or not renewing privileges;

ii. Acceptance of the Practitioner's surrender of Clinical Privileges, or any restriction of such privileges by a Practitioner:

a) While the Practitioner is under investigation relating to possible incompetence or improper professional conduct; or

b) In return for not conducting such an investigation or proceeding.

iii. Withdrawal of an initial application by Practitioner for Clinical Privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action;

iv. Practitioner does not apply for renewal of Clinical Privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action; or

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v. Summary suspension imposed for more than thirty (30) days based on the Practitioner's professional competence or professional conduct of the Practitioner that adversely effects, or could adversely affect the health and welfare of a patient and is the result of a professional review action.

2. Timeframe for filing an NPDB Report

a. CalOptima shall file an NPDB Report within thirty (30) calendar days from the date the adverse action was taken or authority to provide care to CalOptima patients is voluntarily surrendered.

3. Fair Hearing Rights

a. Except in the event of a summary suspension in effect less than thirty-one (31) consecutive days or a surrender or restriction of authority to provide care to CalOptima patients, CalOptima shall file a NPDB Report after the Practitioner has had the opportunity to either waive or exhaust his/her fair hearing rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

4. Notification to the Practitioner

a. The NPDB will mail a copy of the submitted report to the Practitioner named in the report. The Practitioner will have the opportunity to review the report for accuracy, and may add a statement to the report, or may dispute the report directly with the NPDB.

5. Additional Reports

a. CalOptima shall file a Revision-to-Action report to supplement an initial report to the NPDB if the summary suspension of a Practitioner is modified or revised as part of CalOptima's final decision in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

D. Persons at CalOptima Required to Report

1. Reports to the Medical Board Based on Business and Professions Code § 805

a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.A.2. of this Policy, the Chief Medical Officer or Physician Designee who participates on CPRC, shall file an 805 Report with the Medical Board in the appropriate time required in Section III.A.3. of this Policy.

2. Reports to the Medical Board Based on Business and Professions Code § 805.01

a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.B.2. of this Policy, the Chief Medical Officer or Physician Designee who participates on CPRC, shall file an 805.01 Report with the Medical Board in the appropriate time required in Section III.B.3. of this Policy.

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3. Reports to the National Practitioner Data Bank

   a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.C.2. of this Policy, Quality Improvement Credentialing Supervisor, shall file a report with the NPDB in the appropriate time required in Section III.C.3. of this Policy.

IV. ATTACHMENTS

A. Sample 805 Report
B. Sample 805.01 Report
C. Sample NPDB Report

V. REFERENCES

A. California Welfare and Institutions Code, § 14087.58(b)
B. California Business and Professions Code, §§ 805, 805.01 and 809
C. California Health and Safety Code § 1370
D. CalOptima Contract for Health Care Services
E. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima PACE Program Agreement
H. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. Health Care Quality Improvement Act of 1986 (HCQIA), 42 U.S.C. §11101 *et seq*.
K. National Practitioner Data Bank regulations, 45 CFR Part 60
L. National Practitioner Data Bank 2015 Guidebook
M. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing (2018) CR:7, Element A, Factor 2

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. TBD

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	TBD	GG.1657ΔPP	Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting	Med-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Clinical Privileges	As provided in the NPDB Guidebook, Clinical Privileges are privileges, and other circumstances (e.g. network participation and panel membership) in which a physician, dentist, or other health care Practitioner is permitted to furnish medical care by a health care entity.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Health Network	A Physician Hospital Consortium (PHC), physician medical group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Practitioner	For purposes of this Policy, Practitioner means a "Licentiate" as that term is defined in Business and Professions Code Section 805 and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168. Practitioner also means an individual who is licensed or otherwise authorized by a State to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized as that term is defined in the Health Care Quality Improvement Act of 1986 (HCQIA) and its implementing regulations.

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MEDICAL BOARD OF CALIFORNIA
Central Complaint Unit

HEALTH FACILITY/PEER REVIEW REPORTING FORM
(Required by Section 805 of the California Business & Professions Code)

NOTE: Certain actions, with respect to staff privileges, membership or employment of physicians, podiatrists, licensed midwifes and physician assistants must be reported to the Medical Board of California when they are imposed or voluntarily accepted for a medical disciplinary cause or reason. Reports on osteopathic physicians, dentists and psychologists should be directed to their respective Boards. Please see the reverse/second page of this form for further information.

******PLEASE PRINT OR TYPE******

REPORTING ENTITY

Please check type of Reporting Entity	☐ Health Care Facility or Clinic – §805(a)(1)(A)	☐ Health Care Service Plan - §805(a)(1)(B)
	☐ Professional Society - §805(a)(1)(c)	☐ Medical Group or Employer - §805(a)(1)(D)
	☐ Ambulatory Surgical Center - §805(a)(1)(A)	

Name	Telephone #
Chief Executive Officer/Medical Director/Administrator	Chief of Medical Staff
Name of person preparing report	Telephone #

Street address City State Zip code

LICENTIATE

Name License #

☐ Physician ☐ Podiatrist ☐ Licensed Midwife ☐ Physician Assistant

ACTION TAKEN

Date(s) of Action(s) and Duration (attached additional sheets if necessary)

Type(s) of Action(s) - Check all that apply. **CHECK HERE IF THIS IS A SUPPLEMENTAL REPORT** ☐

(a) For a medical disciplinary cause or reason:
- ☐ Denial/rejection of application for staff privileges
- ☐ Denial/rejection of application for membership
- ☐ Termination or revocation of staff privileges
- ☐ Termination or revocation of membership
- ☐ Termination or revocation of employment

(b) For a cumulative total of 30 days or more for any 12 month period, and for a medical disciplinary cause or reason:
- ☐ Restriction(s) imposed on staff privileges
- ☐ Restriction(s) imposed on membership
- ☐ Restriction(s) imposed on employment
- ☐ Restriction(s) voluntarily accepted on staff privileges
- ☐ Restriction(s) voluntarily accepted on membership
- ☐ Restriction(s) voluntarily accepted on employment

If staff privileges were restricted, list specific restrictions imposed or voluntarily accepted:

(c) Following notice of an impending investigation based on information indicating medical disciplinary cause or reason:
- ☐ Licentiate resigned from staff
- ☐ Licentiate resigned from membership
- ☐ Licentiate resigned from employment
- ☐ Licentiate took leave of absence from staff
- ☐ Licentiate took leave of absence from membership
- ☐ Licentiate took leave of absence from employment

(d) For a summary suspension that remains in effect for a period in excess of 14 days for a medical disciplinary cause or reason:
- ☐ Imposition of summary suspension on staff privileges
- ☐ Imposition of summary suspension on employment
- ☐ Imposition of summary suspension on membership

DESCRIPTION OF ACTION: Attach additional sheet(s) describing the facts and circumstances of the medical disciplinary cause or reason and any other relevant information related to the action taken, including, but not limited to, the number of cases reviewed, time frame covered, any patient deaths involved, any malpractice filings as a result of the physician's actions, any expert/peer opinions obtained, etc.

Signature Date
Chief Executive Officer/Medical Director/Administrator

Signature Date
Chief of Medical Staff

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2528 FAX: (916) 263-2435 www.mbc.ca.gov

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ADDITIONAL INFORMATION

To complete this form, for definition of terms, when, how, and who should report, please refer to Section 805 of the California Business and Professions Code. You may access this information via www.leginfo.ca.gov under California Law, Business and Professions Code.

PLEASE NOTE: Section 805(k) of the California Business and Professions Code states: "A willful failure to file an 805 report by any person who is designated or otherwise required by law to file an 805 report is punishable by a fine not to exceed one hundred thousand dollars ($100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, 'willful' means a voluntary and intentional violation of a known legal duty."

Section 805(l) of the California Business and Professions Code states: "Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that, under no circumstances shall exceed fifty thousand dollars ($50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code."

Section 805(m) of the California Business and Professions Code states: "A health care service plan registered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that negotiates and enters into a contract with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, when determining participation with the plan or insurer, shall evaluate, on a case-by-case basis, licentiates who are the subject of an 805 report, and not automatically exclude or deselect these licentiates."

CONFIDENTIALITY

This report is not a waiver of the confidentiality of medical records and committee reports. The contents of this report may be viewed only by those persons specified in Section 800(c) of the Business and Professions Code, except as required by Section 805.5 of the Business and Professions Code.

COPY TO LICENTIATE

A copy of the 805 report, with a cover letter informing the Licentiate of his or her right to submit additional statements or other information pursuant to Section 800(c) of the Business and Professions Code, must be sent by the reporting entity to the Licentiate.

SUPPLEMENTAL REPORT

A supplemental report must be made within thirty (30) days following the date the Licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as corrective action by the reporting entity.

MEDICAL BOARD OF CALIFORNIA
Central Complaint Unit

HEALTH FACILITY/PEER REVIEW REPORTING FORM
(Required by Section 805.01 of the California Business & Professions Code)

NOTE: Certain actions, with respect to staff privileges, membership or employment of physicians, physician assistants, licensed midwifes and podiatrists must be reported to the Medical Board of California when they are imposed or voluntarily accepted for a medical disciplinary cause or reason.

REPORTING ENTITY

Please check type of Reporting Entity	☐ Health Care Facility or Clinic – §805(a)(1)(A)	☐ Health Care Service Plan - §805(a)(1)(B)
	☐ Professional Society - §805(a)(1)(c)	☐ Medical Group or Employer - §805(a)(1)(D)
	☐ Ambulatory Surgical Center - §805(a)(1)(A)	
Name		Telephone #
Chief Executive Officer/Medical Director/Administrator		Chief of Medical Staff
Name of person preparing report		Telephone #
Street address	City	State Zip code

LICENTIATE

Name			License #
☐ Physician	☐ Podiatrist	☐ Licensed Midwife	☐ Physician Assistant

REASON FOR FORMAL INVESTIGATION

Reason for formal investigation that resulted in recommended action:

- ☐ Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public.
- ☐ The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
- ☐ Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.
- ☐ Sexual misconduct with one or more patients during a course of treatment or an examination.

RECOMMENDED ACTION

- ☐ Termination or revocation of staff privileges, membership or employment
- ☐ Summary suspension of staff privileges, membership or employment
- ☐ Restriction of staff privileges, membership or employment

List proposed specific restrictions:

Date final decision/recommendation made:

Signature Date
Chief Executive Officer/Medical Director/Administrator

Signature Date
Chief of Medical Staff

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2528 FAX: (916) 263-2435 www.mbc.ca.gov

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California Business and Professions Code Section 805.01

(a) As used in this section, the following terms have the following definitions:

(1) "Agency" has the same meaning as defined in Section 805.

(2) "Formal investigation" means an investigation performed by a peer review body based on an allegation that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) occurred.

(3) "Licentiate" has the same meaning as defined in Section 805.

(4) "Peer review body" has the same meaning as defined in Section 805.

(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file a report with the relevant agency within 15 days after a peer review body makes a final decision or recommendation regarding the disciplinary action, as specified in subdivision (b) of Section 805, resulting in a final proposed action to be taken against a licentiate based on the peer review body's determination, following formal investigation of the licentiate, that any of the acts listed in paragraphs (1) to (4), inclusive, may have occurred, regardless of whether a hearing is held pursuant to Section 809.2. The licentiate shall receive a notice of the proposed action as set forth in Section 809.1, which shall also include a notice advising the licentiate of the right to submit additional explanatory or exculpatory statements electronically or otherwise.

(1) Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public. This paragraph shall not be construed to affect or require the imposition of immediate suspension pursuant to Section 809.5.

(2) The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Sexual misconduct with one or more patients during a course of treatment or an examination.

(c) The relevant agency shall be entitled to inspect and copy the following documents in the record of any formal investigation required to be reported pursuant to subdivision (b):

(1) Any statement of charges.

(2) Any document, medical chart, or exhibit.

(3) Any opinions, findings, or conclusions.

(4) Any certified copy of medical records, as permitted by other applicable law.

(d) The report provided pursuant to subdivision (b) and the information disclosed pursuant to subdivision (c) shall be kept confidential and shall not be subject to discovery, except that the information may be reviewed as provided in subdivision (c) of Section 800 and may be disclosed in any subsequent disciplinary hearing conducted pursuant to the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) The report required under this section shall be in addition to any report required under Section 805.

(f) A peer review body shall not be required to make a report pursuant to this section if that body does not make a final decision or recommendation regarding the disciplinary action to be taken against a licentiate based on the body's determination that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) may have occurred.

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U.S. Department of Health & Human Services

NPDB NATIONAL PRACTITIONER DATA BANK

Draft Medical Malpractice Payment Report (MMPR)
(Do not mail this form to the NPDB)

This form is for your convenience in drafting Medical Malpractice Payment Reports for ultimate submission to the NPDB. **Do not mail this form to the NPDB.** Medical Malpractice Payment Reports must be submitted to the National Practitioner Data Bank (NPDB) using the Integrated Querying and Reporting Service (IQRS), the Querying and Reporting XML Service (QRXS), or the Interface Control Document (ICD) Transfer Program (ITP), which are available at *https://www.npdb.hrsa.gov*.

Please provide as much of the following information as possible. Failure to provide sufficient information to permit identification of a single subject will result in the report being rejected, necessitating resubmission. If spaces are provided for multiple responses to an item, you only need to complete as many of the responses as you have information for. There is no need to repeat responses or enter "Not Applicable," etc.

OMB # 0915-0126 expiration date 03/31/2021

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0126. Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857.

Personal Information

Subject Name

Last Name	First Name	Middle Name	Suffix
(25 characters)	*(15 characters)*	*(15 characters)*	*(4 characters)*

Is Subject Deceased? ☐ No ☐ Unknown ☐ Yes – Deceased Date (MMDDYYYY):

Gender: ☐ Male ☐ Female ☐ Unknown

Birth Date (MMDDYYYY)**:**

Home Address/Address of Record

(See List A-1 and A-2 for information on filling out non-U.S. and military addresses)

Street Address *(40 characters)*:
Address Line 2 *(40 characters)*:
City *(28 characters)*:
State (Choose State code from List A-1):
ZIP Code: -
Country (If U.S., leave blank; *20 characters*):

Work Information

Organization Name *(60 characters)*:
Address
(See Lists A-1 and A-2 for information on filling out non-U.S. and military addresses)

Street Address *(40 characters)*:
Address Line 2 *(40 characters)*:
City *(28 characters)*:
State (Choose State code from List A-1):
ZIP Code: -
Country (If U.S., leave blank; *20 characters*):

Social Security Numbers (SSN) (Format NNNNNNNNN)

1. **2.**
3. **4.**

Drug Enforcement Administration (DEA) Numbers *(9 characters)*

1. **2.**
3. **4.**

Professional Schools Attended (Name, City, State/Country; *200 characters*) **Year of Graduation** (Format YYYY)

1.
2.
3.
4.
5.

Occupation and State Licensure Information

(Provide at least one license. Check 'No License' if the subject does not have a State License Number. Up to 60 licenses may be provided.)

1. **State License Number** *(16 characters)*: **OR** ☐ No License
   State of Licensure (Choose State code from List A-1):
   Occupation/Field of Licensure (Choose one three-digit code from List B):
   Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

2. **State License Number** *(16 characters)*: **OR** ☐ No License
   State of Licensure (Choose State code from List A-1):
   Occupation/Field of Licensure (Choose one three-digit code from List B):
   Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

3. **State License Number** *(16 characters)*: **OR** ☐ No License
   State of Licensure (Choose State code from List A-1):
   Occupation/Field of Licensure (Choose one three-digit code from List B):
   Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

4. **State License Number** *(16 characters)*: **OR** ☐ No License
   State of Licensure (Choose State code from List A-1):
   Occupation/Field of Licensure (Choose one three-digit code from List B):
   Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

5. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

6. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

7. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

8. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

9. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

10. State License Number *(16 characters)*: **OR** ☐ No License

State of Licensure (Choose State code from List A-1):

Occupation/Field of Licensure (Choose one three-digit code from List B):

Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*)**:**

Hospital Affiliation(s)

	Name *(60 characters)*	**City** *(28 characters)*	**State** (Choose State code from List A-1)
1.			
2.			
3.			
4.			
5.			

Payments by This Payer for This Practitioner

If you made a single payment for multiple practitioners and if the settlement agreement or judgment does not specify an amount for each practitioner, you must allocate the total payment between the practitioners and specify an amount greater than zero for this practitioner. If a settlement agreement specifically states that no payment was made for this practitioner, do not file this report. The total amount paid or to be paid by you for all practitioners must be specified in the appropriate field. You must file a separate report for each practitioner named in the claim and judgment or settlement unless the judgment or settlement specifically states that no payment was made for that practitioner.

Amount of This Payment for This Practitioner
(Format NNNNNNNNN.NN): $

Date of This Payment (MMDDYYYY):

Select the payment type (i.e., Single or Multiple) to indicate whether the payment specified in the Amount of This Payment field is a single final payment or is one of multiple payments to be paid in series. Only the first payment of a series of payments must be reported, except when a preliminary payment is made before a final settlement is reached.

If this payment represents a preliminary payment prior to settlement:

1. Select One of Multiple Payments in this field; enter the preliminary payment amount in both the Amount of This Payment for This Practitioner and the Total Amount Paid or to be Paid by This Payer for This Practitioner fields; and
2. Explain the circumstances of the preliminary payment in the Description of the Judgment or Settlement field.
3. Once the settlement is reached, file a Correction Report and provide the revised total amount of all payments in the Total Amount Paid or to be Paid by This Payer for This Practitioner field.

If this payment represents a payment made after a final settlement, only the first payment of a series of payments must be reported. In these cases:

1. Report the amount of the first payment in the Amount of This Payment for This Practitioner field.
2. Complete the Total Amount Paid or to be Paid by This Payer for This Practitioner field, consistent with the instructions below.

This Payment Represents: ☐ A Single Final Payment ☐ One of Multiple Payments

If this report concerns a preliminary payment before a final settlement is reached and the total amount ultimately to be paid is unknown:

1. Enter only the amount of this payment; and
2. Explain in the Description of the Judgment or Settlement field;
3. Then, file a Correction Report once the settlement is reached and the total amount is known.

If this payment represents a payment made after a final settlement, only the first payment of a series of payments must be reported. If this payment is part of a structured settlement, report the cost of purchasing the structured settlement arrangement or the present value of the total payments to be made over the lifetime of the obligation if a structured settlement arrangement is not purchased.

Total Amount Paid or to Be Paid by This Payer for This Practitioner
(Format NNNNNNNNN.NN): $

Payment Result of: ☐ Judgment ☐ Settlement ☐ Payment Prior to Settlement

Date of Judgment or Settlement, if Any (MMDDYYYY):

Adjudicative Body Case Number (if Applicable; *20 characters*):

Adjudicative Body Name (if Applicable; *60 characters*):

Court File Number (if Applicable; *10 characters*):

Description of Judgment or Settlement and Any Conditions, Including Terms of Payment
(Limit 4,000 characters including spaces and punctuation)

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Payments by This Payer for Other Practitioners in This Case	
Total Amount Paid or to Be Paid by This Payer for All Practitioners in This Case (Including the Amount Specified Above for This Practitioner; Format NNNNNNNNN.NN):	$
Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case:	

Payment Information

Relationship of Entity to This Practitioner (Choose one from list):

Note: A health insurance company, managed care organization, or health care entity (such as a hospital, health plan, group practice, government agency and department that provides health care services) that makes a payment for a practitioner on its own staff because the company pays its own malpractice claims rather than having coverage for malpractice claims under an insurance policy issued by another company should report as a Self-Insured Organization. A State fund should select the code "State Medical Malpractice Payment Fund as the Primary Payer for the Practitioner" if the fund is the payer of first resort for a claim and select the code "State Medical Malpractice Payment Fund as a Secondary Payer for the Practitioner" if the fund is the payer for any amount in excess of the primary amount.

- ☐ Insurance Company – Primary Insurer
- ☐ Insurance Company – Excess Insurer
- ☐ Self-Insured Organization
- ☐ Insurance Guaranty Fund
- ☐ State Medical Malpractice Payment Fund as the Primary Payer for This Practitioner
- ☐ State Medical Malpractice Payment Fund as a Secondary Payer for This Practitioner

Payments by Others for This Practitioner

Complete if your entity is an Insurance Company or a Self-Insured Organization.

Has a State Guaranty Fund or State Excess Judgment Fund Made a Payment for This Practitioner in This Case, or Is Such a Payment Expected to Be Made?

- ☐ Yes
- ☐ No
- ☐ Unknown

Amount Paid or Expected to Be Paid by the State Fund (Format NNNNNNNNN.NN): $

Complete if your entity is an Insurance Company, an Insurance Guaranty Fund or a State Medical Malpractice Payment Fund.

Has a Self-Insured Organization and/or Other Insurance Company/Companies Made Payment(s) for This Practitioner in This Case, or Is/Are Such Payment(s) Expected to Be Made?

- ☐ Yes
- ☐ No
- ☐ Unknown

Amount Paid or Expected to Be Paid by Self-Insured Organization(s) and/or Other Insurance Company/Companies (Format NNNNNNNNN.NN): $

Classification of Act(s) or Omission(s)

Patient Information

Patient's Age at Time of Initial Event (enter 0 days if the patient is a fetus):
- ☐ Days (if less than 1 month)
- ☐ Months (if less than 1 year)
- ☐ Years
- ☐ Unknown

Patient's Gender: ☐ Male ☐ Female ☐ Unknown

Patient Type: ☐ Inpatient ☐ Outpatient ☐ Both ☐ Unknown

Description of the Medical Condition With Which the Patient Presented for Treatment (Prior to the Event That Led to the Malpractice Allegation)

Enter a narrative description of the actual diagnosis with which the patient presented for treatment. Do not report a misdiagnosis. If the patient had more than one condition, enter the condition most applicable to the alleged acts or omissions. *(Limit 4,000 characters including spaces and punctuation)*

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Description of the Procedure Performed

Enter a narrative description of the treatment rendered by the insured to the patient for the initial medical condition specified in this report. If more than one procedure was performed by the insured, report the one that is most significant to the claims generation. *(Limit 4,000 characters including spaces and punctuation)*

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Nature of Allegation (choose one from list)**:**

- ☐ Anesthesia Related
- ☐ Behavioral Health Related
- ☐ Diagnosis Related
- ☐ Equipment/Product Related
- ☐ IV & Blood Products Related
- ☐ Medication Related
- ☐ Monitoring Related
- ☐ Obstetrics Related
- ☐ Surgery Related
- ☐ Treatment Related
- ☐ Other Miscellaneous

Specific Allegation (Select the most significant allegation first.)

Note: Only select the same code for both allegations if the alleged act or omission occurred more than once and on different dates.

1. **Specific Allegation** (Choose one three-digit code from List C):

   Description (Only complete for Specific Allegation Code 999; *60 characters*)*:*

   Date of Event Associated With Allegation or Incident (MMDDYYYY):

2. **Specific Allegation** (Choose one three-digit code from List C):

   Description (Only complete for Specific Allegation Code 999; *60 characters*)*:*

   Date of Event Associated With Allegation or Incident (MMDDYYYY):

Outcome (Choose one from list)**:**

- ☐ Emotional injury only
- ☐ Insignificant injury
- ☐ Minor temporary injury
- ☐ Major temporary injury
- ☐ Minor permanent injury
- ☐ Major permanent injury
- ☐ Significant permanent injury
- ☐ Quadriplegic, brain damage, lifelong care
- ☐ Death
- ☐ Cannot be determined from available records

Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based

Reporting entities must use this field to summarize the allegations of the plaintiff or claimant in demanding payment even if the reporting entity believes these allegations to be without merit. Reporters may also use this section to summarize important issues in the case and to provide, as needed, additional information not reported in the Classification of Acts or Omissions section of this report. *(Limit 4,000 characters including spaces and punctuation)*

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Entity Internal Report Reference

This optional field allows your entity to include an internal file number or other reference information to help you identify this report in your files. This information is not used by the NPDB, but it will be provided on copies of the report sent to queriers.

Entity Internal Report Reference (e.g., claim number; *20 characters*):

Customer Use

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use (*20 characters*):

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Approval of Recommended Revisions to CalOptima Finance Policies

Contact
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions
Authorize revisions to the following CalOptima policies:
1. FF.1001: Capitation Payments; and
2. CMC.3001: Payment Arrangements to Health Networks – Capitation Payments.

Background
CalOptima establishes new or 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.

Discussion
Staff recommends revisions to the following CalOptima policies:

- CalOptima Policy FF.1001: Capitation Payments. This policy establishes a process for CalOptima to remit timely and accurate capitation payments to a health network. CalOptima revised this policy pursuant to the CalOptima annual review process to ensure alignment with current operations and regulatory requirements. CalOptima removed references to Kaiser Foundation Health Plan, Inc., and updated the period to consider retroactive activities from six (6) months to twelve (12) months to be in line with current eligibility processing at CalOptima.

- CalOptima Policy CMC.3001: Payment Arrangements to Health Networks – Capitation Payments. This policy outlines the process for timely and accurate capitation payments to a health network as set forth in the Cal MediConnect Health Network Contract. CalOptima revised this policy pursuant to the CalOptima annual review process to ensure alignment with current operations and regulatory requirements. CalOptima updated the period to consider retroactive activities for the Medi-Cal capitation component from six (6) months to twelve (12) months to be in line with current eligibility processing at CalOptima.

Fiscal Impact
The recommended action to approve updates to CalOptima Policies FF.1001 and CMC.3001 is projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to retroactive activities.

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Rationale for Recommendation

The recommended action reflects CalOptima's ongoing efforts to keep policies up to date with regulatory guidance and operational practices.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Policy FF.1001: Capitation Payments (redlined and clean)
2. CalOptima Policy CMC.3001: Payment Arrangements to Health Networks – Capitation Payments (redlined and clean)

/s/ Richard Sanchez — *05/27/2020*

Authorized Signature — **Date**

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Policy:	FF.1001
Title:	**Capitation Payments**
Department:	Finance
Section:	Accounting
Interim CEO Approval:	
Effective Date:	01/01/2007
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20200604 BOD Review Only

I. PURPOSE

This policy establishes a process for CalOptima to remit timely and accurate Capitation Payments~~*~~ to a Health Network.

II. POLICY

A. Capitation Payment

1. CalOptima shall pay a Capitation Payment to a Health Network in accordance with the Contract for Health Care Services and the provisions set forth in this Policy.

2. CalOptima shall base a Capitation Payment on the number of Members enrolled with CalOptima by the California Department of Health Care Services (DHCS).

~~3. If DHCS determines that an individual was not eligible for Medi-Cal services and retroactively terminates eligibility, CalOptima shall recoup payments made to a Health Network for such individual. In such instances, a Health Network may pursue payment directly from the individual.~~

3. Section II.B, Section III.B, and III.C. of this Policy related to Capitation Rates for Acquired Immune Deficiency Syndrome (AIDS) and End Stage Renal Disease (ESRD) shall not apply to Kaiser Foundation Health Plan (Kaiser).

4. Effective July 1, 2019, CalOptima shall pay a ~~capitation payment~~Capitation Payment to a ~~health network~~Health Network for ~~members~~Members who are eligible for services under the California Children's Services (CCS) Program in accordance with the ~~health network's~~Health Network's Contract for Health Care Services, the CalOptima Board of Directors (BOD)-approved payment methodology, and the terms and conditions of CalOptima policy.

   a. In the event a CCS-eligible ~~member~~Member meets the ~~end stage renal disease (~~ESRD~~)~~ qualification criteria set forth in Section II.B.2.a of this Policy, CalOptima may make a ~~capitation payment~~Capitation Payment to the ~~member's health network~~Member's Health Network at the ESRD ~~capitation rate~~Capitation Rate in accordance with the provisions set forth in this Policy.

B. Capitation Rate for ~~Acquired Immune Deficiency Syndrome (~~AIDS~~),~~ or ESRD

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1. CalOptima may make a Capitation Payment to a Health Network at the AIDS Capitation Rate for an eligible Member in accordance with the Contract for Health Care Services and the provisions set forth in this Policy.

    a. A Health Network may receive Capitation Payment at the AIDS Capitation Rate for a Member who:

        i. Is twenty-one (21) years of age, or older;

        ii. Has a confirmed diagnosis of AIDS, consistent with the current definition adopted by the Federal Centers for Disease Control and Prevention (CDC); and

        iii. Has such diagnosis formally recorded, dated, and signed by a treating physician in the Member's Medical Record.

    b. To receive a Capitation Payment at the AIDS Capitation Rate, a Health Network shall submit Human Immunodeficiency Virus (HIV)/AIDS Quality Indicators to CalOptima within the time frame set forth in this Policy.

    c. A Health Network shall notify CalOptima of a change in an eligible Member's status within the time frame set forth in this Policy.

2. CalOptima may make a Capitation Payment to a Health Network at the ESRD Capitation Rate for an eligible Member in accordance with the Contract for Health Care Services and the provisions set forth in this Policy.

    a. A Health Network may receive Capitation Payment at the ESRD Capitation Rate for a Member who:

        i. Has a confirmed diagnosis of ESRD; and

        ii. Has begun a regular course of dialysis that is formally recorded, dated, and signed by a treating physician and documented in the Member's Medical Record.

    b. Upon notice, CalOptima shall transition an eligible Member to CalOptima Direct (COD) in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

    c. To receive a Capitation Payment at the ESRD Capitation Rate, a Health Network shall submit documentation for an eligible Member within the time frame set forth in this Policy.

    d. A Health Network shall notify CalOptima of a change in an eligible Member's status within the time frame set forth in this Policy.

    e. CalOptima shall recoup payments made to a Health Network if CalOptima determines by subsequent Encounter data review, or a clinical review, that a Member for whom CalOptima made a Capitation Payment at the ESRD Capitation Rate did not meet administrative, or clinical, requirements as defined herein.

3. Except as provided in Section II.B.2.b. of this Policy, if a Member meets both the criteria for the AIDS Capitation Rate, as set forth in Section II.B.1.a. of this Policy and criteria for the ESRD Capitation Rate, as set forth in Section II.B.2.a. of this Policy, CalOptima shall make a Health Network Capitation Payment for such Member at the ESRD Capitation Rate.

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C. CalOptima may recoup any amounts it identifies as improperly paid to a Health Network by an offset to the following month's Capitation Payment.

D. If a Health Network identifies an overpayment of a Capitation 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.

E. CalOptima may adjust Capitation Rates during the contract period.

F. Notwithstanding anything to the contrary contained in the Contract for Health Care Services, or this Policy, CalOptima's obligation to render payments shall be subject to CalOptima's receipt of funding from the State of California.

G. A Health Network shall report any and all disputes related to payment or enrollment, except as specified in Section II.D. of this Policy, in writing, to CalOptima's Accounting Department within ninety (90) calendar days after receipt of payment. Failure to dispute within the established time frame indicates acceptance by the Health Network and a waiver of its right to dispute.

III. PROCEDURE

A. Capitation Payment

1. CalOptima shall pay a Capitation Payment to only one (1) Primary Physician Group and one (1) Primary Hospital of a Physician Hospital Consortium (PHC), one (1) Shared Risk Group (SRG), or one (1) Health Maintenance Organization (HMO) for enrolled Members covered by the Health Network.

    a. The Primary Physician Group and Primary Hospital of a PHC, SRG, or HMO receiving the Capitation Payment shall ensure compliance with CalOptima's financial security requirements as set forth in CalOptima Policy FF.3002: Financial Oversight.

    b. A Health Network shall handle subsequent payments internally for any sub-capitation, or other subcontractor arrangements.

2. CalOptima shall pay the Capitation Payment on, or about, the fifteenth (15th) calendar day of the month to which Capitation Payment applies.

3. CalOptima shall pay the Capitation Rate for Members on a daily prorated basis with ~~retroactivity up to six (6) months.~~routine adjustments for Retroactive Terminations of Eligibility up to twelve (12) months. The Capitation Payment shall be for the current month and adjustments for the prior twelve (12) months (thirteen (13) total months). In the event Retroactive Terminations of Eligibility implicate potential refunds or recoupments in excess of this timeframe, such actions will be evaluated on a case-by-case basis.

4. Within three (3) working days of check issuance, the CalOptima Information Services (IS) Department shall post a ~~member~~Member-level detail report to CalOptima's Secure File Transfer Protocol (SFTP) site, which the ~~health network~~Health Network may use to reconcile the ~~capitation payment~~Capitation Payment.

B. Acquired Immune Deficiency Syndrome (AIDS) Capitation Rate

For 20200604 BOD Review Only

1. CalOptima shall make a Health Network Capitation Payment at the AIDS Capitation Rate for a Member who meets criteria as set forth in Section II.B.1.a. of this Policy effective the month in which the confirmed diagnosis of AIDS is made for the Member and reported to CalOptima.

2. A Health Network shall submit a copy of a Member's Medical Record with the confirmed diagnosis of AIDS to the CalOptima Health Network Relations Department as notification that the Health Network is eligible to receive a Capitation Payment at the AIDS Capitation Rate for such Member.

    a. A Health Network shall submit a copy of the eligible Member's Medical Record with the confirmed diagnosis of AIDS no later than sixty (60) calendar days after the date of the confirmed diagnosis of AIDS.

    b. CalOptima shall make a Health Network Capitation Payment at the AIDS Capitation Rate for an eligible Member on a daily prorated basis with retroactivity up to sixty (60) calendar days from the date CalOptima receives such Member's Medical Record with the confirmed diagnosis of AIDS.

    c. If a Health Network submits an eligible Member's Medical Record with the confirmed diagnosis of AIDS within sixty (60) calendar days after the date the Member received a confirmed diagnosis of AIDS, the Health Network shall receive a Capitation Payment at the AIDS Capitation Rate effective the date such Member received a confirmed diagnosis of AIDS.

    d. If a Health Network submits an eligible Member's Medical Record with the confirmed diagnosis of AIDS after sixty (60) calendar days have passed from the date the Member received a confirmed diagnosis of AIDS, the Health Network shall receive a Capitation Payment at the AIDS Capitation Rate effective sixty (60) calendar days prior to CalOptima's receipt of such Member's Medical Record with the confirmed diagnosis of AIDS, and shall not receive that rate for any time period before such effective date.

3. Subject to the provisions of this Policy, a Health Network shall receive a Capitation Payment at the AIDS Capitation Rate for an eligible Member for whom a Health Network has submitted a Medical Record with a confirmed diagnosis of AIDS until the Health Network reports a status change for the Member.

4. A Health Network shall notify CalOptima's Health Network Relations Department, in writing, of a change in the status of an eligible Member by the twenty-fifth (25th) calendar day of each month. A change in the status of an eligible Member status includes, but is not limited to, death.

C. ~~End Stage Renal Disease (~~ESRD~~)~~ Capitation Rate

1. A Member's dialysis center and treating physician shall complete a Form CMS 2728-U3 and report a Member with ESRD to a national ESRD patient registry established by Title XVIII, Section 1881 of the Social Security Act. The Member's dialysis center, or dialysis training facility, shall maintain Form CMS-2728-U3.

2. A Health Network~~, except Kaiser Foundation Health Plan (Kaiser),~~ shall submit a copy of Form CMS-2728-U3 to the CalOptima Health Network Relations Department as notification that the Member is eligible for enrollment in CalOptima Direct in accordance with CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.

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a. If CalOptima receives Form CMS-2728-U3 for a Member from a Health Network on, or before, the fifteenth (15th) calendar day of the month, CalOptima shall make a Capitation Payment at the ESRD Capitation Rate for the Member for the month that CalOptima received Form CMS-2728-U3 and any subsequent months until CalOptima transitions the Member into CalOptima Direct. For example, if CalOptima receives Form CMS-2728-U3 from a Health Network on, or before, June 15, CalOptima shall make a Capitation Payment at the ESRD Capitation Rate for the month of June.

b. If CalOptima receives Form CMS-2728-U3 for a Member from a Health Network after the fifteenth (15th) calendar day of the month, CalOptima shall make a Capitation Payment at the ESRD Capitation Rate for the Member for the month following the date that CalOptima received Form CMS-2728-U3, and any subsequent months until CalOptima transitions the Member into CalOptima Direct. For example, if CalOptima receives Form CMS-2728-U3 from a Health Network on or after June 16, CalOptima shall not make a Capitation Payment at the ESRD Capitation Rate for the month of June. CalOptima shall make a Capitation Payment at the ESRD Capitation Rate for the month of July.

~~3. Kaiser shall submit a copy of Form CMS-2728-U3 to the CalOptima Health Network Relations Department as notification that Kaiser is eligible to receive a Capitation Payment at the ESRD Capitation Rate.~~

~~a. Kaiser shall submit Form CMS-2728-U3 no later than sixty (60) calendar days after the date the Member begins a regular course of dialysis.~~

~~b. Kaiser shall receive a Capitation Payment at the ESRD Capitation Rate for the Member on a daily prorated basis with retroactivity up to sixty (60) calendar days from the date CalOptima receives Form CMS-2728-U3.~~

~~i. If Kaiser submits Form CMS-2728-U3 within sixty (60) calendar days after the date the Member begins a regular course of dialysis, Kaiser shall receive a Capitation Payment at the ESRD Capitation Rate effective the date the Member began a regular course of dialysis.~~

~~ii. If Kaiser submits Form CMS-2728-U3 after sixty (60) calendar days have passed from the date the Member begins a regular course of dialysis, Kaiser shall receive a Capitation Payment at the ESRD Capitation Rate effective sixty (60) calendar days prior to CalOptima's receipt of Form CMS-2728-U3, and shall not receive that rate for any time period before this effective date.~~

~~c. Subject to the provisions of this Policy, Kaiser shall receive a Capitation Payment at the ESRD Capitation Rate on an ongoing basis for an eligible Member for whom Kaiser has submitted Form CMS-2728-U3 until Kaiser reports a change in the status of the Member.~~

~~d. Kaiser shall notify CalOptima's Health Network Relations Department, in writing, of a change in the status of an eligible Member by the twenty-fifth (25th) day of each month. A change in the status of an eligible Member includes, but is not limited to, termination of regular dialysis treatment due to death, kidney transplant, or recovery.~~

~~e. If an eligible Member receives a kidney transplant:~~

~~i. Kaiser shall notify CalOptima pursuant to Section III.C.3.d. of this Policy; and~~

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ii. ~~CalOptima shall cease to pay the ESRD Capitation Rate for the Member effective the month immediately following the month in which such Member receives a kidney transplant.~~

f. ~~Kaiser shall report all services related to an eligible Member's ESRD in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements.~~

~~4.~~3. CalOptima's Case Management Department may conduct a clinical review of a Member whose ESRD status is unclear to determine if such Member meets the criteria as set forth in Section III.C.2.a. of this Policy.

IV. ATTACHMENT(S)

A. End Stage Renal Disease Medical Evidence Report - Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3 [~~08/15~~10/18])

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 DD.2006: Enrollment In/Eligibility with CalOptima Direct
~~D. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements~~
~~E.~~D. CalOptima Policy FF.3002: Financial Oversight
~~F.~~E. Department of Health Care Services (DHCS) All Plan Letter 17-003: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers
~~G.~~F. Title XVIII, Social Security Act, Section 1881
~~H.~~G. Title 42, Code of Federal Regulations (C.F.R), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
03/14/2011	Department of Health Care Services (DHCS)
06/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/03/2008	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.1001	Capitation Payments	Medi-Cal
Revised	07/01/2008	FF.1001	Capitation Payments	Medi-Cal
Revised	01/01/2011	FF.1001	Capitation Payments	Medi-Cal
Revised	09/01/2014	FF.1001	Capitation Payments	Medi-Cal
Revised	01/01/2017	FF.1001	Capitation Payments	Medi-Cal
Revised	07/01/2017	FF.1001	Capitation Payments	Medi-Cal
Revised	01/01/2019	FF.1001	Capitation Payments	Medi-Cal
Revised	03/01/2019	FF.1001	Capitation Payments	Medi-Cal
Revised	07/01/2019	FF.1001	Capitation Payments	Medi-Cal
Revised		FF.1001	Capitation Payments	Medi-Cal

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IX. GLOSSARY

Term	Definition
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
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.
Capitation Rate	The per capita rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age, and gender.
Contract for Health Care Services	For the purposes of this policy, the written instrument between CalOptima and a Physician Hospital Consortium (PHC), Shared Risk Group (SRG), Health Maintenance Organization (HMO), or other entity, for the purpose of providing delegated services to assigned Members. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on the PHC, SRG, or HMO; DHCS Medi-Cal Managed Care Division All Plan and Policy Letters; and Contract Interpretation.
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.
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.
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

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Term	Definition
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital to provide Medi-Cal services to a common set of assigned Members, 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).
Retroactive Terminations of Eligibility	A determination by the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) that a Member, as of a specified date in the past, is no longer eligible for benefits under the specified CalOptima program.
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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Policy:	FF.1001
Title:	**Capitation Payments**
Department:	Finance
Section:	Accounting
Interim CEO Approval:	
Effective Date:	01/01/2007
Revised Date:	

Applicable to:

- ☒ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☐ Administrative

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I. PURPOSE

This policy establishes a process for CalOptima to remit timely and accurate Capitation Payments to a Health Network.

II. POLICY

A. Capitation Payment

1. CalOptima shall pay a Capitation Payment to a Health Network in accordance with the Contract for Health Care Services and the provisions set forth in this Policy.

2. CalOptima shall base a Capitation Payment on the number of Members enrolled with CalOptima by the California Department of Health Care Services (DHCS).

3. Section II.B, Section III.B, and III.C. of this Policy related to Capitation Rates for Acquired Immune Deficiency Syndrome (AIDS) and End Stage Renal Disease (ESRD) shall not apply to Kaiser Foundation Health Plan (Kaiser).

4. Effective July 1, 2019, CalOptima shall pay a Capitation Payment to a Health Network for Members who are eligible for services under the California Children's Services (CCS) Program 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 CalOptima policy.

   a. In the event a CCS-eligible Member meets the ESRD qualification criteria set forth in Section II.B.2.a of this Policy, CalOptima may make a Capitation Payment to the Member's Health Network at the ESRD Capitation Rate in accordance with the provisions set forth in this Policy.

B. Capitation Rate for AIDS or ESRD

1. CalOptima may make a Capitation Payment to a Health Network at the AIDS Capitation Rate for an eligible Member in accordance with the Contract for Health Care Services and the provisions set forth in this Policy.

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a. A Health Network may receive Capitation Payment at the AIDS Capitation Rate for a Member who:

i. Is twenty-one (21) years of age, or older;

ii. Has a confirmed diagnosis of AIDS, consistent with the current definition adopted by the Federal Centers for Disease Control and Prevention (CDC); and

iii. Has such diagnosis formally recorded, dated, and signed by a treating physician in the Member's Medical Record.

b. To receive a Capitation Payment at the AIDS Capitation Rate, a Health Network shall submit Human Immunodeficiency Virus (HIV)/AIDS Quality Indicators to CalOptima within the time frame set forth in this Policy.

c. A Health Network shall notify CalOptima of a change in an eligible Member's status within the time frame set forth in this Policy.

2. CalOptima may make a Capitation Payment to a Health Network at the ESRD Capitation Rate for an eligible Member in accordance with the Contract for Health Care Services and the provisions set forth in this Policy.

a. A Health Network may receive Capitation Payment at the ESRD Capitation Rate for a Member who:

i. Has a confirmed diagnosis of ESRD; and

ii. Has begun a regular course of dialysis that is formally recorded, dated, and signed by a treating physician and documented in the Member's Medical Record.

b. Upon notice, CalOptima shall transition an eligible Member to CalOptima Direct (COD) in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

c. To receive a Capitation Payment at the ESRD Capitation Rate, a Health Network shall submit documentation for an eligible Member within the time frame set forth in this Policy.

d. A Health Network shall notify CalOptima of a change in an eligible Member's status within the time frame set forth in this Policy.

e. CalOptima shall recoup payments made to a Health Network if CalOptima determines by subsequent Encounter data review, or a clinical review, that a Member for whom CalOptima made a Capitation Payment at the ESRD Capitation Rate did not meet administrative, or clinical, requirements as defined herein.

3. Except as provided in Section II.B.2.b. of this Policy, if a Member meets both the criteria for the AIDS Capitation Rate, as set forth in Section II.B.1.a. of this Policy and criteria for the ESRD Capitation Rate, as set forth in Section II.B.2.a. of this Policy, CalOptima shall make a Health Network Capitation Payment for such Member at the ESRD Capitation Rate.

C. CalOptima may recoup any amounts it identifies as improperly paid to a Health Network by an offset to the following month's Capitation Payment.

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D. If a Health Network identifies an overpayment of a Capitation 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.

E. CalOptima may adjust Capitation Rates during the contract period.

F. Notwithstanding anything to the contrary contained in the Contract for Health Care Services, or this Policy, CalOptima's obligation to render payments shall be subject to CalOptima's receipt of funding from the State of California.

G. A Health Network shall report any and all disputes related to payment or enrollment, except as specified in Section II.D. of this Policy, in writing, to CalOptima's Accounting Department within ninety (90) calendar days after receipt of payment. Failure to dispute within the established time frame indicates acceptance by the Health Network and a waiver of its right to dispute.

III. PROCEDURE

A. Capitation Payment

1. CalOptima shall pay a Capitation Payment to only one (1) Primary Physician Group and one (1) Primary Hospital of a Physician Hospital Consortium (PHC), one (1) Shared Risk Group (SRG), or one (1) Health Maintenance Organization (HMO) for enrolled Members covered by the Health Network.

   a. The Primary Physician Group and Primary Hospital of a PHC, SRG, or HMO receiving the Capitation Payment shall ensure compliance with CalOptima's financial security requirements as set forth in CalOptima Policy FF.3002: Financial Oversight.

   b. A Health Network shall handle subsequent payments internally for any sub-capitation, or other subcontractor arrangements.

2. CalOptima shall pay the Capitation Payment on, or about, the fifteenth (15th) calendar day of the month to which Capitation Payment applies.

3. CalOptima shall pay the Capitation Rate for Members on a daily prorated basis with routine adjustments for Retroactive Terminations of Eligibility up to twelve (12) months. The Capitation Payment shall be for the current month and adjustments for the prior twelve (12) months (thirteen (13) total months). In the event Retroactive Terminations of Eligibility implicate potential refunds or recoupments in excess of this timeframe, such actions will be evaluated on a case-by-case basis.

4. Within three (3) working days of check issuance, the CalOptima Information Services (IS) Department shall post a Member-level detail report to CalOptima's Secure File Transfer Protocol (SFTP) site, which the Health Network may use to reconcile the Capitation Payment.

B. Acquired Immune Deficiency Syndrome (AIDS) Capitation Rate

1. CalOptima shall make a Health Network Capitation Payment at the AIDS Capitation Rate for a Member who meets criteria as set forth in Section II.B.1.a. of this Policy effective the month in which the confirmed diagnosis of AIDS is made for the Member and reported to CalOptima.

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2. A Health Network shall submit a copy of a Member's Medical Record with the confirmed diagnosis of AIDS to the CalOptima Health Network Relations Department as notification that the Health Network is eligible to receive a Capitation Payment at the AIDS Capitation Rate for such Member.

   a. A Health Network shall submit a copy of the eligible Member's Medical Record with the confirmed diagnosis of AIDS no later than sixty (60) calendar days after the date of the confirmed diagnosis of AIDS.

   b. CalOptima shall make a Health Network Capitation Payment at the AIDS Capitation Rate for an eligible Member on a daily prorated basis with retroactivity up to sixty (60) calendar days from the date CalOptima receives such Member's Medical Record with the confirmed diagnosis of AIDS.

   c. If a Health Network submits an eligible Member's Medical Record with the confirmed diagnosis of AIDS within sixty (60) calendar days after the date the Member received a confirmed diagnosis of AIDS, the Health Network shall receive a Capitation Payment at the AIDS Capitation Rate effective the date such Member received a confirmed diagnosis of AIDS.

   d. If a Health Network submits an eligible Member's Medical Record with the confirmed diagnosis of AIDS after sixty (60) calendar days have passed from the date the Member received a confirmed diagnosis of AIDS, the Health Network shall receive a Capitation Payment at the AIDS Capitation Rate effective sixty (60) calendar days prior to CalOptima's receipt of such Member's Medical Record with the confirmed diagnosis of AIDS, and shall not receive that rate for any time period before such effective date.

3. Subject to the provisions of this Policy, a Health Network shall receive a Capitation Payment at the AIDS Capitation Rate for an eligible Member for whom a Health Network has submitted a Medical Record with a confirmed diagnosis of AIDS until the Health Network reports a status change for the Member.

4. A Health Network shall notify CalOptima's Health Network Relations Department, in writing, of a change in the status of an eligible Member by the twenty-fifth (25th) calendar day of each month. A change in the status of an eligible Member status includes, but is not limited to, death.

C. ESRD Capitation Rate

1. A Member's dialysis center and treating physician shall complete a Form CMS 2728-U3 and report a Member with ESRD to a national ESRD patient registry established by Title XVIII, Section 1881 of the Social Security Act. The Member's dialysis center, or dialysis training facility, shall maintain Form CMS-2728-U3.

2. A Health Network shall submit a copy of Form CMS-2728-U3 to the CalOptima Health Network Relations Department as notification that the Member is eligible for enrollment in CalOptima Direct in accordance with CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.

   a. If CalOptima receives Form CMS-2728-U3 for a Member from a Health Network on, or before, the fifteenth (15th) calendar day of the month, CalOptima shall make a Capitation Payment at the ESRD Capitation Rate for the Member for the month that CalOptima received Form CMS-2728-U3 and any subsequent months until CalOptima transitions the Member into CalOptima Direct. For example, if CalOptima receives Form CMS-2728-U3

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from a Health Network on, or before, June 15, CalOptima shall make a Capitation Payment at the ESRD Capitation Rate for the month of June.

b. If CalOptima receives Form CMS-2728-U3 for a Member from a Health Network after the fifteenth (15th) calendar day of the month, CalOptima shall make a Capitation Payment at the ESRD Capitation Rate for the Member for the month following the date that CalOptima received Form CMS-2728-U3, and any subsequent months until CalOptima transitions the Member into CalOptima Direct. For example, if CalOptima receives Form CMS-2728-U3 from a Health Network on or after June 16, CalOptima shall not make a Capitation Payment at the ESRD Capitation Rate for the month of June. CalOptima shall make a Capitation Payment at the ESRD Capitation Rate for the month of July.

3. CalOptima's Case Management Department may conduct a clinical review of a Member whose ESRD status is unclear to determine if such Member meets the criteria as set forth in Section III.C.2.a. of this Policy.

IV. ATTACHMENT(S)

A. End Stage Renal Disease Medical Evidence Report - Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3 [10/18])

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 DD.2006: Enrollment In/Eligibility with CalOptima Direct
D. CalOptima Policy FF.3002: Financial Oversight
E. Department of Health Care Services (DHCS) All Plan Letter 17-003: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers
F. Title XVIII, Social Security Act, Section 1881
G. Title 42, Code of Federal Regulations (C.F.R), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
03/14/2011	Department of Health Care Services (DHCS)
06/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/03/2008	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.1001	Capitation Payments	Medi-Cal
Revised	07/01/2008	FF.1001	Capitation Payments	Medi-Cal
Revised	01/01/2011	FF.1001	Capitation Payments	Medi-Cal
Revised	09/01/2014	FF.1001	Capitation Payments	Medi-Cal
Revised	01/01/2017	FF.1001	Capitation Payments	Medi-Cal
Revised	07/01/2017	FF.1001	Capitation Payments	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2019	FF.1001	Capitation Payments	Medi-Cal
Revised	03/01/2019	FF.1001	Capitation Payments	Medi-Cal
Revised	07/01/2019	FF.1001	Capitation Payments	Medi-Cal
Revised		FF.1001	Capitation Payments	Medi-Cal

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IX. GLOSSARY

Term	Definition
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
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.
Capitation Rate	The per capita rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age, and gender.
Contract for Health Care Services	For the purposes of this policy, the written instrument between CalOptima and a Physician Hospital Consortium (PHC), Shared Risk Group (SRG), Health Maintenance Organization (HMO), or other entity, for the purpose of providing delegated services to assigned Members. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on the PHC, SRG, or HMO; DHCS Medi-Cal Managed Care Division All Plan and Policy Letters; and Contract Interpretation.
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.
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.
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

For 2020 BOD Review Only

Term	Definition
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital to provide Medi-Cal services to a common set of assigned Members, 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).
Retroactive Terminations of Eligibility	A determination by the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) that a Member, as of a specified date in the past, is no longer eligible for benefits under the specified CalOptima program.
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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For 20200604 BOD Review Only

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0046

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS *Check one:* ☐ Initial ☐ Re-entitlement ☐ Supplemental

1. Name *(Last, First, Middle Initial)*

2. Medicare Beneficiary Identifier or Social Security Number

3. Date of Birth *(mm/dd/yyyy)*

4. Patient Mailing Address *(Include City, State and Zip)*

5. Phone Number *(including area code)*

6. Sex
☐ Male ☐ Female

7. Ethnicity
☐ Not Hispanic or Latino ☐ Hispanic or Latino (Complete Item 9)

8. Country/Area of Origin or Ancestry

9. Race *(Check all that apply)*
☐ White
☐ Black or African American
☐ American Indian/Alaska Native
Print Name of Enrolled/Principal Tribe _____
☐ Asian
☐ Native Hawaiian or Other Pacific Islander*
☐ Other

10. Is patient applying for ESRD Medicare coverage?
☐ Yes ☐ No

11. Current Medical Coverage *(Check all that apply)*
☐ Medicaid ☐ Medicare ☐ Employer Group Health Insurance
☐ VA ☐ Medicare Advantage ☐ Other ☐ None

12. Height
INCHES _____ OR
CENTIMETERS _____

13. Dry Weight
POUNDS _____ OR
KILOGRAMS _____

14. Primary Cause of Renal Failure *(Use code from back of form)*

15. Employment Status *(6 mos prior and current status)*

Prior	Current	
☐	☐	Unemployed
☐	☐	Employed Full Time
☐	☐	Employed Part Time
☐	☐	Homemaker
☐	☐	Retired due to Age/Preference
☐	☐	Retired (Disability)
☐	☐	Medical Leave of Absence
☐	☐	Student

16. Co-Morbid Conditions *(Check all that apply currently and/or during last 10 years)* *See instructions

a. ☐ Congestive heart failure
b. ☐ Atherosclerotic heart disease ASHD
c. ☐ Other cardiac disease
d. ☐ Cerebrovascular disease, CVA, TIA*
e. ☐ Peripheral vascular disease*
f. ☐ History of hypertension
g. ☐ Amputation
h. ☐ Diabetes, currently on insulin
i. ☐ Diabetes, on oral medications
j. ☐ Diabetes, without medications
k. ☐ Diabetic retinopathy
l. ☐ Chronic obstructive pulmonary disease
m. ☐ Tobacco use (current smoker)
n. ☐ Malignant neoplasm, Cancer
o. ☐ Toxic nephropathy
p. ☐ Alcohol dependence
q. ☐ Drug dependence*
r. ☐ Inability to ambulate
s. ☐ Inability to transfer
t. ☐ Needs assistance with daily activities
u. ☐ Institutionalized
☐ 1. Assisted Living
☐ 2. Nursing Home
☐ 3. Other Institution
v. ☐ Non-renal congenital abnormality
w. ☐ None

17. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
b. Was patient under care of a nephrologist? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
c. Was patient under care of kidney dietitian? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
d. What access was used on first outpatient dialysis: ☐ AVF ☐ Graft ☐ Catheter ☐ Other
If not AVF, then: Is maturing AVF present? ☐ Yes ☐ No
Is maturing graft present? ☐ Yes ☐ No

18. Laboratory Values Within **45** Days Prior to the Most Recent ESRD Episode. (Lipid Profile within 1 Year of Most Recent ESRD Episode).

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a.1. Serum Albumin (g/dl)	___.___		d. HbA1c	___ ___.___%	
a.2. Serum Albumin Lower Limit	___.___		e. Lipid Profile TC	___ ___ ___	
a.3. Lab Method Used (BCG or BCP)			LDL	___ ___ ___	
b. Serum Creatinine (mg/dl)	___ ___.___		HDL	___ ___	
c. Hemoglobin (g/dl)	___ ___.___		TG	___ ___ ___ ___	

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

19. Name of Dialysis Facility

20. Medicare Provider Number *(for item 19)*

21. Primary Dialysis Setting
☐ Home ☐ Dialysis Facility ☐ SNF/Long Term Care Facility

22. Primary Type of Dialysis
☐ Hemodialysis (Sessions per week____/hours per session____)
☐ CAPD ☐ CCPD ☐ Other

23. Date Regular Chronic Dialysis Began *(mm/dd/yyyy)*

24. Date Patient Started Chronic Dialysis at Current Facility *(mm/dd/yyyy)*

25. Has patient been informed of kidney transplant options?
☐ Yes ☐ No

26. If patient NOT informed of transplant options, please check all that apply:
☐ Patient declined information
☐ Patient has not been assessed
☐ Patient is not eligible medically
☐ Other

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

27. Date of Transplant *(mm/dd/yyyy)*	28. Name of Transplant Hospital	29. Medicare Provider Number for Item 28

Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.

30. Enter Date *(mm/dd/yyyy)*	31. Name of Preparation Hospital	32. Medicare Provider number for Item 31

33. Current Status of Transplant *(if functioning, skip items 36 and 37)*	34. Type of Donor:
☐ Functioning ☐ Non-Functioning	☐ Deceased ☐ Living Related ☐ Living Unrelated
35. If Non-Functioning, Date of Return to Regular Dialysis *(mm/dd/yyyy)*	36. Current Dialysis Treatment Site
	☐ Home ☐ Dialysis Facility ☐ SNF/Long Term Care Facility

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)

37. Name of Training Provider	38. Medicare Provider Number of Training Provider (for Item 37)
39. Date Training Began *(mm/dd/yyyy)*	40. Type of Training ☐ Hemodialysis a. ☐ Home b. ☐ In Center ☐ CAPD ☐ CCPD ☐ Other
41. This Patient is Expected to Complete *(or has completed)* Training and will Self-dialyze on a Regular Basis. ☐ Yes ☐ No	42. Date When Patient Completed, or is Expected to Complete, Training *(mm/dd/yyyy)*

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

43. Printed Name and Signature of Physician personally familiar with the patient's training			44. UPIN or NPI of Physician in Item 43
a.) Printed Name	b.) Signature	c.) Date *(mm/dd/yyyy)*	

E. PHYSICIAN IDENTIFICATION

45. Attending Physician *(Print)*	46. Physician's Phone No. *(include Area Code)*	47. UPIN or NPI of Physician in Item 45

PHYSICIAN ATTESTATION

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

48. Attending Physician's Signature of Attestation *(Same as Item 45)*	49. Date *(mm/dd/yyyy)*
50. Physician Recertification Signature	51. Date *(mm/dd/yyyy)*

52. Remarks

F. OBTAIN SIGNATURE FROM PATIENT

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

53. Signature of Patient *(Signature by mark must be witnessed.)*	54. Date *(mm/dd/yyyy)*

G. PRIVACY STATEMENT

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-700520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health. Additional disclosures may be found in the Federal Register notice cited above. You should be aware that P.L.100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

LIST OF PRIMARY CAUSES OF RENAL DISEASE

Item 14. Primary Cause of Renal Failure should be completed by the attending physician from the list below. Enter the ICD-10-CM code to indicate the primary cause of end stage renal disease. If there are several probable causes of renal failure, choose one as primary. **An ICD-10-CM code is effective as of October 1, 2015.**

ICD-10	DESCRIPTION
DIABETES	
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication
GLOMERULONEPHRITIS	
N00.8	Acute nephritic syndrome with other morphologic changes
N01.9	Rapidly progressive nephritic syndrome with unspecified morphologic changes
N02.8	Recurrent and persistent hematuria with other morphologic changes
N03.0	Chronic nephritic syndrome with minor glomerular abnormality
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions
N03.2	Chronic nephritic syndrome with diffuse membranous glomerulonephritis
N03.3	Chronic nephritic syndrome with diffuse mesangial proliferative glomerulonephritis
N03.4	Chronic nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis
N03.5	Chronic nephritic syndrome with diffuse mesangiocapillary glomerulonephritis
N03.6	Chronic nephritic syndrome with dense deposit disease
N03.7	Chronic nephritic syndrome with diffuse crescentic glomerulonephritis
N03.8	Chronic nephritic syndrome with other morphologic changes
N03.9	Chronic nephritic syndrome with unspecified morphologic changes
N04.0	Nephrotic syndrome with minor glomerular abnormality
N04.1	Nephrotic syndrome with focal and segmental glomerular lesions
N04.2	Nephrotic syndrome with diffuse membranous glomerulonephritis
N04.3	Nephrotic syndrome with diffuse mesangial proliferative glomerulonephritis
N04.4	Nephrotic syndrome with diffuse endocapillary proliferative glomerulonephritis
N04.5	Nephrotic syndrome with diffuse mesangiocapillary glomerulonephritis
N04.6	Nephrotic syndrome with dense deposit disease
N04.7	Nephrotic syndrome with diffuse crescentic glomerulonephritis
N04.8	Nephrotic syndrome with other morphologic changes
N04.9	Nephrotic syndrome with unspecified morphologic changes
N05.9	Unspecified nephritic syndrome with unspecified morphologic changes
N07.0	Hereditary nephropathy, not elsewhere classified with minor glomerular abnormality
SECONDARY GLOMERULONEPHRITIS/VASCULITIS	
D59.3	Hemolytic-uremic syndrome
D69.0	Allergic purpura
I77.89	Other specified disorders of arteries and arterioles
M31.0	Hypersensitivity angiitis
M31.1	Thrombotic microangiopathy
M31.31	Wegener's granulomatosis with renal involvement
M31.7	Microscopic polyangiitis
M32.0	Drug-induced systemic lupus erythematosus
M32.10	Systemic lupus erythematosus, organ or system involvement unspecified
M32.14	Glomerular disease in systemic lupus erythematosus
M32.15	Tubulo-interstitial nephropathy in systemic lupus erythematosus
M34.89	Other systemic sclerosis
INTERSTITIAL NEPHRITIS/PYELONEPHRITIS	
N10	Acute tubulo-interstitial nephritis
N11.9	Chronic tubulo-interstitial nephritis, unspecified
N13.70	Vesicoureteral-reflux, unspecified
N13.8	Other obstructive and reflux uropathy 2
TRANSPLANT COMPLICATIONS	
T86.00	Unspecified complication of bone marrow transplant
T86.10	Unspecified complication of kidney transplant
T86.20	Unspecified complication of heart transplant
T86.40	Unspecified complication of liver transplant
T86.819	Unspecified complication of lung transplant
T86.859	Unspecified complication of intestine transplant
T86.899	Unspecified complication of other transplanted tissue

LIST OF PRIMARY CAUSES OF RENAL DISEASE

Item 14. Primary Cause of Renal Failure should be completed by the attending physician from the list below. Enter the ICD-10-CM code to indicate the primary cause of end stage renal disease. If there are several probable causes of renal failure, choose one as primary. **An ICD-10-CM code is effective as of October 1, 2015.**

ICD-10	DESCRIPTION
HYPERTENSION/LARGE VESSEL DISEASE	
I12.9	Hypertensive chronic kidney disease with stage 1through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I15.0	Renovascular hypertension
I15.8	Other secondary hypertension
I75.81	Atheroembolism of kidney
CYSTIC/HEREDITARY/CONGENITAL/OTHER DISEASES	
E72.04	Cystinosis
E72.53	Hyperoxaluria
E75.21	Fabry (-Anderson) disease
N07.8	Hereditary nephropathy, not elsewhere classified with other morphologic lesions
N31.9	Neuromuscular dysfunction of bladder, unspecified
Q56.0	Hermaphroditism, not elsewhere classified
Q60.2	Renal agenesis, unspecified
Q61.19	Other polycystic kidney, infantile type
Q61.2	Polycystic kidney, adult type
Q61.4	Renal dysplasia
Q61.5	Medullary cystic kidney
Q61.8	Other cystic kidney diseases
Q62.11	Congenital occlusion of ureteropelvic junction
Q62.12	Congenital occlusion of ureterovesical orifice
Q63.8	Other specified congenital malformations of kidney
Q64.2	Congenital posterior urethral valves
Q79.4	Prune belly syndrome
Q85.1	Tuberous sclerosis
Q86.8	Other congenital malformation syndromes due to known exogenous causes
Q87.1	Congenital malformation syndromes predominantly associated with short stature
Q87.81	Alport syndrome
NEOPLASMS/TUMORS	
C64.9	Malignant neoplasm of unspecified kidney, except renal pelvis
C80.1	Malignant (primary) neoplasm, unspecified
C85.93	Non-Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes
C88.2	Heavy chain disease
C90.00	Multiple myeloma not having achieved remission
D30.9	Benign neoplasm of urinary organ, unspecified
D41.00	Neoplasm of uncertain behavior of unspecified kidney
D41.9	Neoplasm of uncertain behavior of unspecified urinary organ
E85.9	Amyloidosis, unspecified
N05.8	Unspecified nephritic syndrome with other morphologic changes
DISORDERS OF MINERAL METABOLISM	
E83.52	Hypercalcemia
GENITOURINARY SYSTEM	
A18.10	Tuberculosis of genitourinary system, unspecified
N28.9	Disorder of kidney and ureter, unspecified
ACUTE KIDNEY FAILURE	
N17.0	Acute kidney failure with tubular necrosis
N17.1	Acute kidney failure with acute cortical necrosis
N17.9	Acute kidney failure, unspecified
MISCELLANEOUS CONDITIONS	
B20	Human immunodeficiency virus [HIV] disease
D57.1	Sickle-cell disease without crisis
D57.3	Sickle cell trait
I50.9	Heart failure, unspecified
K76.7	Hepatorenal syndrome
M10.30	Gout due to renal impairment, unspecified site
N14.0	Analgesic nephropathy
N14.1	Nephropathy induced by other drugs, medicaments and biological substances
N14.3	Nephropathy induced by heavy metals
N20.0	Calculus of kidney
N25.89	Other disorders resulting from impaired renal tubular function
N26.9	Renal sclerosis, unspecified
N28.0	Ischemia and infarction of kidney
N28.89	Other specified disorders of kidney and ureter
O90.4	Postpartum acute kidney failure
S37.009A	Unspecified injury of unspecified kidney, initial encounter
Z90.5	Acquired Absence of Kidney

INSTRUCTIONS FOR COMPLETION OF END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

For whom should this form be completed:

This form **SHOULD NOT** be completed for those patients who are in acute renal failure. Acute renal failure is a condition in which kidney function can be expected to recover after a short period of dialysis, i.e., several weeks or months.

This form **MUST BE** completed within 45 days for **ALL** patients beginning any of the following:

Check the appropriate block that identifies the reason for submission of this form.

Initial

For all patients who initially receive a kidney transplant instead of a course of dialysis.

For patients for whom a regular course of dialysis has been prescribed by a physician because they have reached that stage of renal impairment that a kidney transplant or regular course of dialysis is necessary to maintain life. The first date of a regular course of dialysis is the date this prescription is implemented whether as an inpatient of a hospital, an outpatient in a dialysis center or facility, or a home patient. The form should be completed for all patients in this category even if the patient dies within this time period.

Re-entitlement

For beneficiaries who have already been entitled to ESRD Medicare benefits and those benefits were terminated because their coverage stopped 3 years post transplant but now are again applying for Medicare ESRD benefits because they returned to dialysis or received another kidney transplant.

For beneficiaries who stopped dialysis for more than 12 months, have had their Medicare ESRD benefits terminated and now returned to dialysis or received a kidney transplant. These patients will be reapplying for Medicare ESRD benefits.

Supplemental

Patient has received a transplant or trained for self-care dialysis within the first 3 months of the first date of dialysis and initial form was submitted.

All items except as follows: To be completed by the attending physician, head nurse, or social worker involved in this patient's treatment of renal disease.

Items 14, 16-17, 25-26, 48-49: To be completed by the attending physician.
Item 43: To be signed by the attending physician or the physician familiar with the patient's self-care dialysis training.
Items 53 and 54: To be signed and dated by the patient.

1. Enter the patient's legal name (Last, first, middle initial). Name should appear exactly the same as it appears on patient's social security or Medicare card.
2. If the patient is covered by Medicare, enter his/her Medicare Beneficiary Identifier as it appears on his/her Medicare card. If the patient has not yet been assigned a Medicare Beneficiary Identifier, enter the Social Security Number as it appears on his/her Social Security Card. **Only enter the Social Security Number if the patient does not have a Medicare Beneficiary Identifier**.
3. Enter patient's date of birth (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.
4. Enter the patient's mailing address (number and street or post office box number, city, state, and ZIP code.)
5. Enter the patient's home area code and telephone number.
6. Check the appropriate block to identify sex.
7. Check the appropriate block to identify ethnicity. Definitions of the ethnicity categories for Federal statistics are as follows:

   Not Hispanic or Latino—A person of culture or origin not described below, regardless of race.

   Hispanic or Latino—A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.
8. Country/Area of origin or ancestry—Complete if information is available or if directed to do so in question 9.
9. Check the appropriate block(s) to identify race. The 1997 OMB standards permit the reporting of more than one race. An individual's response to the race question is based upon self-identification.

   Definitions of the racial categories for Federal statistics are as follows:

   White—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

   Black or African American—A person having origins in any of the Black racial groups of Africa.

   American Indian/Alaska Native—A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

   Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

   Native Hawaiian or Other Pacific Islander—AA person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

   Other Race—For respondents unable to identify with any of these five race categories
10. Check the appropriate yes or no block to indicate if patient is applying for ESRD Medicare. **Note: Even though a person may already be entitled to general Medicare coverage, he/she should reapply for ESRD Medicare coverage.**

DISTRIBUTION OF COPIES:

- **To the Applicant:** Forward the hard copy of this form with original signatures to the Social Security office servicing the claim.
- **To the Dialysis Facility:** Complete the form in Crown Web or maintain a copy with signature's in the patient file.

11. Check **all** the blocks that apply to this patient's current medical insurance status.

    Medicaid—Patient is currently receiving State Medicaid benefits.

    Medicare—Patient is currently entitled to Federal Medicare benefits.

    Employer Group Health Insurance—Patient receives medical benefits through an employee health plan that covers employees, former employees, or the families of employees or former employees.

    VA—Patient is receiving medical care from a Department of Veterans Affairs facility.

    Medicare Advantage—Patient is receiving medical benefits under a Medicare Advantage organization.

    Other Medical Insurance—Patient is receiving medical benefits under a health insurance plan that is not Medicare, Medicaid, Department of Veterans Affairs, HMO/M+C organization, nor an employer group health insurance plan. Examples of other medical insurance are Railroad Retirement and CHAMPUS beneficiaries.

    None—Patient has no medical insurance plan.

12. Enter the patient's most recent recorded height in inches **OR** centimeters at time form is being completed. If entering height in centimeters, round to the nearest centimeter. Estimate or use last known height for those unable to be measured. (Example of inches - 62. DO NOT PUT 5'2") NOTE: For amputee patients, enter height prior to amputation.

13. Enter the patient's most recent recorded dry weight in pounds **OR** kilograms at time form is being completed. If entering weight in kilograms, round to the nearest kilogram.

NOTE: For amputee patients, enter actual dry weight.

14. Primary Cause of Renal Failure should be determined by the attending physician using the appropriate ICD-10-CM code. Enter the ICD-10-CM code from page 3 or 4 of form to indicate the primary cause of end stage renal disease. If there are several probable causes of renal failure, choose one as primary. An ICD-10-CM code is effective as of October 1, 2015. These are the only acceptable causes of end stage renal disease.

15. Check the first box to indicate employment status 6 months prior to renal failure and the second box to indicate current employment status. **Check only one box for each time period**. If patient is under 6 years of age, leave blank.

16. **To be completed by the attending physician**. Check all co-morbid conditions that apply.

    ***Cerebrovascular Disease** includes history of stroke/ cerebrovascular accident (CVA) and transient ischemic attack (TIA).

    ***Peripheral Vascular Disease** includes absent foot pulses, prior typical claudication, amputations for vascular disease, gangrene and aortic aneurysm.

    ***Drug dependence** means dependent on illicit drugs.

17. Prior to ESRD therapy, check the appropriate box to indicate whether the patient received Exogenous erythropoetin (EPO) or equivalent, was under the care of a nephrologist and/or was under the care of a kidney dietitian. Provide vascular access information as to the type of access used (Arterio-Venous Fistula (AVF), graft, catheter (including port device) or other type of access) when the patient first received outpatient dialysis. If an AVF access was not used, was a maturing AVF or graft present?

NOTE: For those patients re-entering the Medicare program after benefits were terminated, Items 18a thru 18c should contain initial laboratory values within 45 days prior to the most recent ESRD episode. Lipid profiles and HbA1c should be within 1 year of the most recent ESRD episode. Some tests may not be required for patients under 21 years of age.

18a1. Enter the serum albumin value (g/dl) and date test was taken. This value and date must be within 45 days prior to first dialysis treatment or kidney transplant.

18a2. Enter the lower limit of the normal range for serum albumin from the laboratory which performed the serum albumin test entered in 19a1.

18a3. Enter the serum albumin lab method used (BCG or BCP).

18b. Enter the serum creatinine value (mg/dl) and date test was taken. **THIS FIELD MUST BE COMPLETED.** Value must be within 45 days prior to first dialysis treatment or kidney transplant.

18c. Enter the hemoglobin value (g/dl) and date test was taken. This value and date must be within 45 days prior to the first dialysis treatment or kidney transplant.

18d. Enter the HbA1c value and the date the test was taken. The date must be within 1 year prior to the first dialysis treatment or kidney transplant.

18e. Enter the Lipid Profile values and date test was taken. These values: TC–Total Cholesterol; LDL–LDL Cholesterol; HDL–HDL Cholesterol; TG–Triglycerides, and date must be within 1 year prior to the first dialysis treatment or kidney transplant.

19. Enter the name of the dialysis facility where patient is currently receiving care and who is completing this form for patient.

20. Enter the 6-digit Medicare identification code of the dialysis facility in item 19.

21. If the person is receiving a regular course of dialysis treatment, check the appropriate **anticipated long-term treatment setting** at the time this form is being completed.

22. If the patient is, or was, on regular dialysis, **check the anticipated long-term primary type of dialysis**: Hemodialysis, (enter the number of sessions prescribed per week and the hours that were prescribed for each session), CAPD (Continuous Ambulatory Peritoneal Dialysis) and CCPD (Continuous Cycling Peritoneal Dialysis), or Other. **Check only one block**. NOTE: Other has been placed on this form to be used only to report IPD (Intermittent Peritoneal Dialysis) and any new method of dialysis that may be developed prior to the renewal of this form by Office of Management and Budget.

23. Enter the date (month, day, year) that a "regular course of chronic dialysis" began. The beginning of the course of dialysis is counted from the beginning of regularly scheduled dialysis necessary for the treatment of end stage renal disease (ESRD) regardless of the dialysis setting. The date of the first dialysis treatment after the physician has determined that this patient has ESRD and has written a prescription for a "regular course of dialysis" is the "Date Regular Chronic Dialysis Began" regardless of whether this prescription was implemented in a hospital/ inpatient, outpatient, or home setting and regardless of any acute treatments received prior to the implementation of the prescription.

NOTE: For these purposes, end stage renal disease means irreversible damage to a person's kidneys so severely affecting his/her ability to remove or adjust blood wastes that in order to maintain life he or she must have either a course of dialysis or a kidney transplant to maintain life.

If re-entering the Medicare program, enter beginning date of the current ESRD episode. Note in Remarks, Item 52, that patient is restarting dialysis.

24. Enter date patient started chronic dialysis at current facility of dialysis services. In cases where patient transferred to current dialysis facility, this date will be after the date in Item 24.

25. Enter whether the patient has been informed of their options for receiving a kidney transplant.

26. If the patient has not been informed of their options (answered "no" to Item 25), then enter all reasons why a kidney transplant was not an option for this patient at this time.

27. Enter the date(s) of the patient's kidney transplant(s). If reentering the Medicare program, enter current transplant date.

28. Enter the name of the hospital where the patient received a kidney transplant on the date in Item 27.

29. Enter the 6-digit Medicare identification code of the hospital in Item 28 where the patient received a kidney transplant on the date entered in Item 27.

30. Enter date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation. This includes hospitalization for transplant workup in order to place the patient on a transplant waiting list.

31. Enter the name of the hospital where patient was admitted as an inpatient in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation.

32. Enter the 6-digit Medicare identification number for hospital in Item 31.

33. Check the appropriate functioning or non-functioning block.

34. Enter the type of kidney transplant organ donor, Deceased, Living Related or Living Unrelated, that was provided to the patient.

35. If transplant is nonfunctioning, enter date patient returned to a regular course of dialysis. If patient did not stop dialysis post transplant, enter transplant date.

36. If applicable, check where patient is receiving dialysis treatment following transplant rejection. A nursing home or skilled nursing facility is considered as home setting.

Self-dialysis Training Patients (Medicare Applicants Only)
Normally, Medicare entitlement begins with the third month after the month a patient begins a regular course of dialysis treatment. This 3-month qualifying period may be waived if a patient begins a self-dialysis training program in a **Medicare approved training facility** and is expected to self-dialyze after the completion of the training program. Please complete items 37-42 if the patient has entered into a self-dialysis training program. Items 37-42 must be completed if the patient is applying for a Medicare waiver of the 3-month qualifying period for dialysis benefits based on participation in a self-care dialysis training program.

37. Enter the name of the provider furnishing self-care dialysis training.

38. Enter the 6-digit Medicare identification number for the training provider in Item 32.

39. Enter the date self-dialysis training began.

40. Check the appropriate block which describes the type of self-care dialysis training the patient began. If the patient trained for hemodialysis, enter whether the training was to perform dialysis in the home setting or in the facility (in center). If the patient trained for IPD (Intermittent Peritoneal Dialysis), report as Other.

41. Check the appropriate block as to whether or not the physician certifies that the patient is expected to complete the training successfully and self-dialyze on a regular basis.

42. Enter date patient completed or is expected to complete self-dialysis training.

43. Enter printed name and signature of the attending physician or the physician familiar with the patient's self-care dialysis training.

44. Enter the National Provider Identifier (NPI) or the Unique Physician Identification Number (UPIN) of physician in Item 43. (See Item 47 for explanation of UPIN.)

45. Enter the name of the physician who is supervising the patient's renal treatment at the time this form is completed.

46. Enter the area code and telephone number of the physician who is supervising the patient's renal treatment at the time this form is completed.

47. Enter the National Provider Identifier (NPI) or the Unique Physician Identification Number (UPIN) of physician in Item 45

A system of physician identifiers is mandated by Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985. It requires a unique identifier for each physician who provides services for which Medicare payment is made. An identifier is assigned to each physician regardless of his or her practice configuration. The UPIN is established in a national Registry of Medicare Physician Identification and Eligibility Records (MPIER). Transamerica Occidental Life Insurance Company is the Registry Carrier that establishes and maintains the national registry of physicians receiving Part B Medicare payment. Its address is: UPIN Registry, Transamerica Occidental Life, P.O. Box 2575, Los Angeles, CA 90051-0575.

The NPI is established by the NPI Enumerator located in Fargo, North Dakota. The NPI Enumerator may be contacted by:

Phone: (800)465-3203 or TTY (800)692-2326.
Email: customerservice@npienumerator.com.
Mail: NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059.

48. To be signed by the physician supervising the patient's kidney treatment. Signature of physician identified in Item 45. A stamped signature is unacceptable.

49. Enter date physician signed this form.

50. To be signed by the physician who is currently following the patient. If the patient had decided initially not to file an application for Medicare, the physician will be re-certifying that the patient is end stage renal, based on the same medical evidence, by signing the copy of the CMS-2728 that was originally submitted and returned to the provider. If you do not have a copy of the original CMS-2728 on file, complete a new form.

51. The date physician re-certified and signed the form.

52. This remarks section may be used for any necessary comments by either the physician, patient, ESRD Network or social security field office.

53. The patient's signature authorizing the release of information to the Department of Health and Human Services must be secured here. **If the patient is unable to sign the form, it should be signed by a relative, a person assuming responsibility for the patient or by a survivor**.

54. The date patient signed form.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0046 (Expires XX/XX/XXXX). The time required to complete this information collection is estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the ESRD Network in your region.

Policy:	CMC.3001
Title:	**Payment Arrangements to Health Networks – Capitation Payments**
Department:	Finance
Section:	Accounting
Interim CEO Approval:	
Effective Date:	07/01/2015
Revised Date:	

Applicable to:

- ☐ Medi-Cal
- ☐ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative

For 20200604 BOD Review Only

I. PURPOSE

This policy outlines the process for timely and accurate Capitation Payments to a Health Network as set forth in the Cal MediConnect ~~Physician Group Services~~Health Network Contract.

II. POLICY

A. CalOptima shall make Capitation Payments to a Health Network in accordance with the Cal MediConnect ~~Physician Group Services~~Health Network Contract and the provisions set forth in this Policy.

B. Capitation Payments shall be a combination of a Medicare component and a Medi-Cal component. For the Medicare component of the Capitation Payment, CalOptima shall base a capitation payment on the number of Members enrolled reported by the Centers for Medicare & Medicaid Services (CMS). For the Medi-Cal component, CalOptima shall base a Capitation Payment on the number of Members enrolled with CalOptima by the California Department of Health Care Services (DHCS).

~~B.~~C. CalOptima shall adjust Capitation Payments made to a Health Network for retroactive additions and deletions of Members by ~~the Centers for Medicare & Medicaid Services (~~CMS~~)~~ and ~~Department of Health Care Services (~~DHCS~~)~~, in accordance with CMS and DHCS regulations.

~~C.~~D. If CalOptima contracts directly with Providers or vendors for services that are partially, or fully, the financial responsibility of a Health Network, CalOptima shall deduct the appropriate cost or percentage of cost from the Health Network's Capitation Payment on a quarterly basis.

~~D.A. A Health Network shall report a dispute related to payments or enrollments in writing to the CalOptima Accounting Department within ninety (90) calendar days after the Health Network's receipt of payment. Failure to dispute within the established time frame indicates acceptance by the Health Network.~~

E. Notwithstanding anything to the contrary contained in the Cal MediConnect ~~Physician Group Services~~Health Network Contract or this Policy, CalOptima's obligation to render payments shall be subject to CalOptima's receipt of funding from DHCS and CMS.

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F. CalOptima may recoup any amounts improperly paid to a Health Network by an offset to the following month's Capitation Payment.

G. If a Health Network identifies an overpayment of a Capitation 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.

~~G.~~ CalOptima may adjust a Health Network's capitation rates during the contract period due to changes in CalOptima revenue received from CMS and/or DHCS, or changes in CalOptima methodologies used to pay capitation to Health Networks.

H. CalOptima shall ~~strive to~~ notify Health Networks of adjustments in capitation rates when given advance notice of such adjustments by CMS and/or DHCS.

I. A Health Network shall report a dispute related to payments or enrollments in writing to the CalOptima Accounting Department within ninety (90) calendar days after the Health Network's receipt of payment. Failure to dispute within the established time frame indicates acceptance by the Health Network.

III. PROCEDURE

A. Capitation Payment

1. CalOptima shall make the Capitation Payments, minus Sanctions or other adjustments, by the twentieth (20th) calendar day of a month for all Members eligible from the first (1st) of that month.

   a. CalOptima shall generate the Medicare component of the Capitation Payment in accordance with the Health Network's Contract for Health Care Services, utilizing eligibility information included in the Monthly Membership Report (MMR) from CMS and FACETS™:

      i. MMR includes the current month and adjustments for any prior month, including Retroactive Terminations of Eligibility with no limit on the look back.

      ii. The Medicare check will be issued for the current and any prior month.

      iii. Within three (3) working days of the check issuance, the CalOptima Information Services (IS) Department shall post a Member-level detail report to CalOptima's Secure File Transfer Protocol (SFTP) site, which the Health Network may use to reconcile the Capitation Payment.

   b. CalOptima shall generate the Medi-Cal component of the Capitation Payment based on eligibility information loaded in FACETS™:

      i. ~~The Medi-Cal component of~~ CalOptima shall pay the Capitation Rate for Members on a daily prorated basis with routine adjustments for Retroactive Terminations of Eligibility up to twelve (12) months. The Capitation Payment shall be for the current month and adjustments for the prior ~~six (6~~twelve (12) months (~~seven (7~~thirteen (13) total months). In the event Retroactive Terminations of Eligibility implicate potential refunds or

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recoupments in excess of this timeframe, such actions will be evaluated on a case-by-case basis.

~~i.~~ii. Within three (3) working days of check issuance, CalOptima IS Department shall post a Member-level detail report to CalOptima's SFTP site, which the Health Network may use to reconcile the Capitation Payment.

~~ii.~~iii. CalOptima shall pay the Medi-Cal component of the Capitation Payment based on the Community Well ~~Managed Long Term Services and Supports (MLTSS)~~ Rate Cohort, unless CalOptima's OneCare Connect eligibility records reflect a different MLTSS Rate Cohort.

~~iii.~~iv. If CMS eligibility records indicate a Member is eligible and DHCS eligibility records do not, CalOptima shall consider the Member eligible and shall pay the Medi-Cal component of the Capitation Payment based on the Community Well ~~MLTSS~~ Rate Cohort, unless otherwise indicated in CalOptima's OneCare Connect eligibility records.

~~2. It is the responsibility of the Health Network to handle any~~Any sub-capitation ~~payments~~ or other ~~subcontractor~~subcontracting arrangements~~.~~

~~B. Vendor Payment Deduction~~

~~1.~~2. ~~CalOptima~~ shall ~~provide a written notification, including detailed information on the cost or percentage of cost, at least thirty (30) calendar days prior to applying the deduction to a Capitation Payment~~be the sole responsibility of the Health Network.

IV. ATTACHMENT(S)

Not Applicable

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~~V.~~

~~VI.~~V. REFERENCE(S)

A. Cal MediConnect Physician Group Services Contract
~~B. CalOptima Policy CMC.1001: Glossary of Terms~~
B. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

~~VII.~~VI. REGULATORY AGENCY APPROVAL(S)

None to Date

~~VIII.~~VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

~~None to Date~~

~~IX.~~VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2015	CMC.3001	Payment Arrangements to Health Networks– Capitation Payments	OneCare Connect
Revised	08/01/2016	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised	05/01/2017	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised	7/01/2018	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised	09/01/2019	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised		CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect

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~~X.~~IX. GLOSSARY

Term	Definition
Cal MediConnect Health Network Contract	A "Cal MediConnect Physician Group Services Contract," "Cal MediConnect PHC-Physician Group Services Contract," Cal MediConnect PHC-Hospital Services Contract," or "Cal MediConnect HMO Services Contract."
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members.
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.
CMS Contract	CalOptima's written agreement with the Centers for Medicare & Medicaid Services (CMS) to provide Covered Services under OneCare Connect.
Covered Service	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the state in this document.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.

For 20200604 BOD Review Only

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), ~~Physician Medical Group (PMG)~~physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	~~An enrollee~~A Member-beneficiary of a CalOptima program.
Provider	~~A~~ All contracted Providers including physicians, Non-physician~~, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician~~ Medical ~~Group,~~Practitioners, ancillary providers, and facilities or ~~other person or institution~~institutions who ~~furnishes~~furnish Covered Services~~.~~
~~Managed Long Term Services and Supports (MLTSS)~~ Rate Cohorts	Department of Health Care Services determined rate categories as follows: ~~1.~~ 1. Institutional. Individuals in long-term care aid codes and/or residing in a long term care facility for 90 days or more. 2. ~~2.~~ HCBS High. Individuals identified as high utilizers of HCBS services and who meet one of the following criteria: a) ~~a)~~ Receiving In-Home Supportive Services (IHSS) and classified as "Severely Impaired" (SI). SI means a person receives at least 20 hours of personal care services per week under the IHSS program; or b) ~~b)~~ Client of a Multipurpose Senior Services Program (MSSP) site, under the associated 1915(c) waiver; or c) ~~c)~~ Receiving Community-Based Adult Services (CBAS). 3. ~~3.~~ HCBS Low. Individuals identified as low utilizers of HCBS, receiving IHSS (less than 20 hours of personal care services per week) and classified as "Not Severely Impaired" (NSI) under the IHSS program. 4. ~~4.~~ Community Well. All other beneficiaries who do not meet criteria for Institutionalized, HCBS High and HCBS Low risk categories.
Retroactive Terminations of Eligibility	A determination by the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) that a , as of a specified date in the past, is no longer eligible for benefits under the specified CalOptima program.
Sanction	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.

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Policy:	CMC.3001
Title:	**Payment Arrangements to Health Networks – Capitation Payments**
Department:	Finance
Section:	Accounting
Interim CEO Approval:	
Effective Date:	07/01/2015
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

For 20200604 BOD Review Only

I. PURPOSE

This policy outlines the process for timely and accurate Capitation Payments to a Health Network as set forth in the Cal MediConnect Health Network Contract.

II. POLICY

A. CalOptima shall make Capitation Payments to a Health Network in accordance with the Cal MediConnect Health Network Contract and the provisions set forth in this Policy.

B. Capitation Payments shall be a combination of a Medicare component and a Medi-Cal component. For the Medicare component of the Capitation Payment, CalOptima shall base a capitation payment on the number of Members enrolled reported by the Centers for Medicare & Medicaid Services (CMS). For the Medi-Cal component, CalOptima shall base a Capitation Payment on the number of Members enrolled with CalOptima by the California Department of Health Care Services (DHCS).

C. CalOptima shall adjust Capitation Payments made to a Health Network for retroactive additions and deletions of Members by CMS and DHCS, in accordance with CMS and DHCS regulations.

D. If CalOptima contracts directly with Providers or vendors for services that are partially, or fully, the financial responsibility of a Health Network, CalOptima shall deduct the appropriate cost or percentage of cost from the Health Network's Capitation Payment on a quarterly basis.

E. Notwithstanding anything to the contrary contained in the Cal MediConnect Health Network Contract or this Policy, CalOptima's obligation to render payments shall be subject to CalOptima's receipt of funding from DHCS and CMS.

F. CalOptima may recoup any amounts improperly paid to a Health Network by an offset to the following month's Capitation Payment.

G. If a Health Network identifies an overpayment of a Capitation 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.

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H. CalOptima may adjust a Health Network's capitation rates during the contract period due to changes in CalOptima revenue received from CMS and/or DHCS, or changes in CalOptima methodologies used to pay capitation to Health Networks. CalOptima shall notify Health Networks of adjustments in capitation rates when given advance notice of such adjustments by CMS and/or DHCS.

I. A Health Network shall report a dispute related to payments or enrollments in writing to the CalOptima Accounting Department within ninety (90) calendar days after the Health Network's receipt of payment. Failure to dispute within the established time frame indicates acceptance by the Health Network.

III. PROCEDURE

A. Capitation Payment

1. CalOptima shall make the Capitation Payments, minus Sanctions or other adjustments, by the twentieth (20th) calendar day of a month for all Members eligible from the first (1st) of that month.

   a. CalOptima shall generate the Medicare component of the Capitation Payment in accordance with the Health Network's Contract for Health Care Services, utilizing eligibility information included in the Monthly Membership Report (MMR) from CMS and FACETS™:

      i. MMR includes the current month and adjustments for any prior month, including Retroactive Terminations of Eligibility with no limit on the look back.

      ii. The Medicare check will be issued for the current and any prior month.

      iii. Within three (3) working days of the check issuance, the CalOptima Information Services (IS) Department shall post a Member-level detail report to CalOptima's Secure File Transfer Protocol (SFTP) site, which the Health Network may use to reconcile the Capitation Payment.

   b. CalOptima shall generate the Medi-Cal component of the Capitation Payment based on eligibility information loaded in FACETS™:

      i. CalOptima shall pay the Capitation Rate for Members on a daily prorated basis with routine adjustments for Retroactive Terminations of Eligibility up to twelve (12) months. The Capitation Payment shall be for the current month and adjustments for the prior twelve (12) months (thirteen (13) total months). In the event Retroactive Terminations of Eligibility implicate potential refunds or recoupments in excess of this timeframe, such actions will be evaluated on a case-by-case basis.

      ii. Within three (3) working days of check issuance, CalOptima IS Department shall post a Member-level detail report to CalOptima's SFTP site, which the Health Network may use to reconcile the Capitation Payment.

      iii. CalOptima shall pay the Medi-Cal component of the Capitation Payment based on the Community Well Rate Cohort, unless CalOptima's OneCare Connect eligibility records reflect a different MLTSS Rate Cohort.

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iv. If CMS eligibility records indicate a Member is eligible and DHCS eligibility records do not, CalOptima shall consider the Member eligible and shall pay the Medi-Cal component of the Capitation Payment based on the Community Well Rate Cohort, unless otherwise indicated in CalOptima's OneCare Connect eligibility records.

2. Any sub-capitation or other subcontracting arrangements shall be the sole responsibility of the Health Network.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Cal MediConnect Physician Group Services Contract
B. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2015	CMC.3001	Payment Arrangements to Health Networks– Capitation Payments	OneCare Connect
Revised	08/01/2016	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised	05/01/2017	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised	7/01/2018	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised	09/01/2019	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised		CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect

For 20200604 BOD Review Only

IX. GLOSSARY

Term	Definition
Cal MediConnect Health Network Contract	A "Cal MediConnect Physician Group Services Contract," "Cal MediConnect PHC-Physician Group Services Contract," Cal MediConnect PHC-Hospital Services Contract," or "Cal MediConnect HMO Services Contract."
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members.
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Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the state in this document.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

For 20200604 BOD Review Only

Term	Definition
Member	A Member-beneficiary of a CalOptima program.
Provider	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish Covered Services
Rate Cohorts	Department of Health Care Services determined rate categories as follows: 1. Institutional. Individuals in long-term care aid codes and/or residing in a long term care facility for 90 days or more. 2. HCBS High. Individuals identified as high utilizers of HCBS services and who meet one of the following criteria: a) Receiving In-Home Supportive Services (IHSS) and classified as "Severely Impaired" (SI). SI means a person receives at least 20 hours of personal care services per week under the IHSS program; or b) Client of a Multipurpose Senior Services Program (MSSP) site, under the associated 1915(c) waiver; or c) Receiving Community-Based Adult Services (CBAS). 3. HCBS Low. Individuals identified as low utilizers of HCBS, receiving IHSS (less than 20 hours of personal care services per week) and classified as "Not Severely Impaired" (NSI) under the IHSS program. 4. Community Well. All other beneficiaries who do not meet criteria for Institutionalized, HCBS High and HCBS Low risk categories.
Retroactive Terminations of Eligibility	A determination by the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) that a , as of a specified date in the past, is no longer eligible for benefits under the specified CalOptima program.
Sanction	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.

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For 2020 04 BOD Review Only

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
18. Consider Approving Updates to Policy EE.1103: Provider Education and Training

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

Recommended Actions
Approve updates to Policy EE.1103 Provider Education and Training, for CalOptima Medi-Cal, OneCare, OneCare Connect, and PACE

Background and Discussion
Policy EE.1103 provides guidance on training and education requirements for CalOptima's Medical, Behavioral Health, and Long-Term Services and Support (LTSS) providers. The policy, first made effective in 2001, impacts all CalOptima lines of business and is aligned with Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) requirements. Policy EE.1103 mandates initial and ongoing training for all CalOptima providers, including but not limited to provider communications, cultural competency, critical incident reporting, and conflict resolution. Staff recently undertook some modifications to this policy to strengthen guidance in the area of member non-discrimination.

Updates made to Policy EE.1103 include the following additions:

1. *Section II B, Line Item 11*:
Section II B of the policy outlines the types of disability and cultural competency training CalOptima requires of its Medi-Cal, Behavioral Health, and LTSS providers. The new verbiage provided in Line Item 11 adds "HIV stigma and non-discrimination requirements" as one of the areas of training.

2. *Section II D, Line Items 1-5:*
Section II D of this policy outlines the areas in which CalOptima, and its Health Networks, shall provide additional ongoing training, as well as the frequency. The changes made to this section expanded the requirements to include mandatory annual refresher training in areas including but not limited to the following: Cultural Competency Training, Seniors and Persons with Disability (SPD) Training, and Access Standards. Apart from the mandated annual training, it highlights four instances where the refresher training is required, including when CalOptima or regulators determine that a Provider has discriminated against a CalOptima member.

3. *Section II.F:*
Section F is a new subsection added to Section II. This subsection stipulates that CalOptima or its Health Networks are required to retain training records for a period of 10 years.

Staff recommends approving updates to Policy EE.1103 in order to align CalOptima's Provider Training and Education requirements with current operational processes and regulatory requirements.

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Fiscal Impact
The recommended action to revise CalOptima Policy EE.1103 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
Approving these modifications will align Provider Training and Education requirements with current operational processes and regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Revised CalOptima Policy EE. 1103 (redlined and clean copy)

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

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Policy:	EE.1103Δ
Title:	**Provider Education and Training**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	
Effective Date:	03/01/2001
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

For 20200604 BOD Review Only

I. PURPOSE

This policy outlines the initial and ongoing training and education requirements for medical, behavioral health, and Long-Term Services and Support (LTSS) Providers, who serve CalOptima's Members participating in CalOptima's programs, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. Providers generally: CalOptima or a Health Network shall provide initial and recurring training to ~~identified~~all contracted Providers who serve CalOptima's Members participating in CalOptima's health care programs. Additionally, CalOptima will provide training to appropriate staff of designated county agencies with which CalOptima partners. Training will include, at a minimum:

1. CalOptima programs and initiatives, including but not limited to the Whole-Child Model (WCM) program and Health Homes Program;
2. CalOptima/Health Network operations;
3. Provider communications;
4. Member rights and responsibilities;
5. CalOptima policies and procedures;
6. Individual Health Education Behavioral Assessment (IHEBA) contract requirements;
7. Member benefits;
8. Claims submission and payment;
9. Coordination of benefits;
10. Conflict resolution;
11. Critical Incident reporting;

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12. Member Grievance and Appeals process;

13. Utilization Management Appeals and Provider dispute resolution process; and

14. Prior authorization process.

15. Cultural competency training;

16. Seniors and Persons with Disabilities (SPD) trainings;

17. Fraud, Waste, and Abuse and compliance training;

18. OneCare Connect Program Overview;

19. Model of Care;

20. Access standards; and

21. Subcontracted Network Certification requirements.

B. Medical, Behavioral Health and LTSS Providers: CalOptima shall require disability and cultural competency training for its medical, behavioral health, and LTSS Providers, including information about the following:

1. Various types of Chronic Conditions prevalent within the target population;

2. Awareness of personal prejudices;

3. Legal obligations to comply with the Americans with Disabilities Act (ADA) requirements and Section 504 of the Rehabilitation Act;

4. Definitions and concepts, such as communication access, alternative formats, medical equipment access, physical access, and access to programs;

5. Types of barriers encountered by the target population;

6. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, wellness principles, and the recovery model;

7. Use of clinical protocols, evidence-based practices, and specific levels of quality outcomes;

8. Use of culturally competent practices and access to services in a culturally competent manner for all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code section 422.56;

9. Working with Members with mental health diagnoses, including crisis prevention and treatment; ~~and~~

10. Working with Members with substance use conditions, including diagnosis and treatment; and

~~10.~~11. HIV stigma and non-discrimination requirements.

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C. CalOptima shall develop and make available training to staff and Providers, as applicable, who interact with Medi-Cal SPD Members, on standards for competency, cultural awareness, and sensitivity.

1. Individuals covered by this requirement include, but are not limited to, CalOptima and Health Network staff, contracted CalOptima and Health Network PCPs, Practitioners, high-volume specialists, and speech, occupational, and physical therapists, in accordance with Medi-Cal Managed Care Division (MMCD) All Plan Letter 11-010 and Welfare and Institutions Code, section 14182(b)(5).

D. CalOptima or Health Networks shall also provide and disseminate additional ongoing training for contracted Providers:

1. Refresher training on an annual basis:

a. Cultural competency training;

b. SPD trainings;

c. Fraud, Waste, and Abuse and compliance training;

d. OneCare Connect Program Overview;

e. Model of Care;

f. Access standards and

g. Subcontracted Network Certification requirements.

2. When conducting **Provider** forums, meetings, outreach visits;

~~1.~~3. When determined necessary;

~~2. Refresher training, on an annual basis, including but not limited to:~~

~~1.~~ ~~Cultural competency training;~~

~~a. **SPD** trainings;~~

~~1.~~ ~~Fraud, Waste, and Abuse and compliance training;~~

~~1.~~ ~~OneCare Connect Program Overview;~~

~~b. Model of Care; and~~

~~c. Access standards.~~

~~3. When conducting **Provider** forums, meetings, and outreach visits; and~~

4. Upon request from Providers~~.~~; and

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5. When CalOptima or one of its regulators determines that a Provider has discriminated against a CalOptima Member.

E. CalOptima shall educate all CalOptima Direct and CalOptima Community Network contracted **Providers**. All **Health Networks** shall educate their contracted **Providers**, in accordance with DHCS and CMS requirements.

F. CalOptima or a Health Network shall retain training records for a period of at least ten (10) years.

III. PROCEDURE

A. Initial and Recurring Training for Contracted Medical, Behavioral Health, and LTSS Providers

1. CalOptima or a Health Network shall conduct training for a newly contracted medical, behavioral health, or LTSS Provider within ten (10) business days from the Provider's placement on Active Status.

2. CalOptima or a Health Network, as necessary, shall make a Provider Manual accessible to all contracted medical, behavioral health, and LTSS Providers. The Provider Manual shall include, at a minimum, the following information:

   a. Updates and revisions;

   b. Overview and Model of Care;

   c. CalOptima or Health Network contact information;

   d. Member benefits covered by CalOptima;

   e. Eligibility determination and verification process;

   f. Quality improvement for health services programs;

   g. Member rights and responsibilities;

   h. Provider billing and reporting;

   i. The Member problem resolution processes;

   j. The authorization process;

   k. Provider cultural and linguistic requirements;

   l. Regulatory and contractual requirements; and

   m. Other activities and services needed to assist Members in optimizing their health status, including assistance with self-management skills or techniques, health education, and other modalities to improve health status.

3. CalOptima or a Health Network shall complete training no later than thirty (30) calendar days from the Provider's placement on Active Status.

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4. Upon completion of the training, the Provider shall sign an acknowledgement notice and shall return the signed acknowledgement notice to CalOptima or the Health Network.

5. If CalOptima or a Health Network is unable to complete the training within the thirty (30) calendar day requirement, CalOptima or Health Network shall send materials to the Provider's office, and document reasons and actions taken due to non-completion of the education.

6. CalOptima and its Health Networks shall track completion of the Provider's education, including the date of completion of the education.

7. A Health Network shall submit a completed Health Network Newly Contracted Provider Office Training Report to CalOptima on a quarterly basis, on or before the twenty-fifth (25th) day of the month, following the end of the quarter. If the twenty-fifth (25th) day falls on a non-business day, the Health Network shall submit the report no later than the next business day.

8. Health Networks shall provide written confirmation that appropriate Health Network staff have been educated and trained, in accordance with the DHCS cultural awareness and sensitivity instructions for SPDs.

IV. ATTACHMENT(S)

A. Health Network Newly Contracted Provider and Practitioner Office Training Form

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
~~C. CalOptima Policy CMC.4001: Member Rights and Responsibilities~~
~~CalOptima Policy CMC.4002: Cultural and Linguistic Services~~
~~D. CalOptima Policy DD.2001: Member Rights and Responsibilities~~
~~E. CalOptima Policy DD.2002: Cultural and Linguistic Services~~
~~F. CalOptima Policy GG.1100: Alcohol and Substance Use Disorder Treatment Services~~
~~G. CalOptima Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities~~
~~H. CalOptima Policy GG.1201: Health Education Programs~~
~~I. CalOptima Policy GG.1203: Individual Health Education Behavioral Assessments~~
~~J. CalOptima Policy HH.2004: Performance Reviews~~
~~K. CalOptima Policy MA.4001: Member Rights and Responsibilities~~
~~L. CalOptima Policy MA.4002: Cultural and Linguistic Services~~
~~M.~~C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
~~N.~~D. Department of Health Care Services (DHCS) All Plan Letter 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities
~~O.~~E. Title 42, Code of Federal Regulations (CFR), §§ 438.3(u), 438.206(c)(2), 438.236(c), and 438.414
~~P. Penal Code, §422.56~~
~~Q.~~F. Welfare and Institutions (W&I) Code, §14182 (b) (5)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/29/2010	Department of Health Care Services (DHCS)
02/24/2013	Department of Health Care Services (DHCS)

For 2/20/2014 BOD Review Only

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2001	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	07/01/2007	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	01/01/2009	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	11/01/2012	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	03/01/2015	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2015	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	08/01/2016	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2017	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	03/07/2019	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Active Status	A Provider's, PCP's, and Practitioner's contract effective date with CalOptima, a Health Network or ~~Physician Medical Group~~physician group. Active status for a Provider, PCP and/or Practitioner added to a contracted medical group shall be the date the PCP and/or Practitioner is approved to provide services to Members within that group.
Appeal	Medi-Cal: A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a ~~s~~Covered Service. Includes a request for a fair hearing in accordance with California Code or Regulations (CCR) Titled 22, Section 51014 and Welfare and Institutions Code section 10950. OneCare and 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.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, C alifornia Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Chronic Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Critical Incident	Critical incident refers to any actual, or alleged, event, or situation, that creates a significant risk of substantial harm to the physical or mental health, safety, or well-being of a Member.
Grievance	Medi-Cal: An expression of dissatisfaction about any matter other than an adverse benefit determination. OneCare and OneCare Connect: Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action. PACE: A complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of Participant care.
Health Homes Program	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP Services that provide supplemental services to eligible Members coordinating the full

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Term	Definition
	range of physical health, behavioral health, and community-based MLTSS needed for chronic conditions.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. In-Home Supportive Services (IHSS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.
Member	An enrollee-beneficiary of a CalOptima program.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).
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.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.
Threshold Language	Medi-Cal/OneCare Connect: Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).~~As specified in annual guidance to Contractors on specific translation requirements for their service areas.~~ OneCare: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.
Whole Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program

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Term	Definition
	administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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Health Network Newly Contracted Provider Office Education Report

Due Date: Before the twenty-fifth (25th) day of the month following the end of each quarter.

Health Network Name:
Year:
Quarter:
Prepared by:
Phone#:

As required by CalOptima policy EE.1103, Provider Education and Training, a health network shall:
1) Conduct training for newly contracted medical, behavioral or LTSS providers within ten (10) business days from the provider's placement on active status.
2) Complete training no later than thirty (30) calendar days from the provider's placement on active status.
3) Obtain a signed acknowledgement notice from the provider.

For Columns C, D and E, indicate the line of business with X or N/A if not applicable.

Provider Name	NPI	Medi-Cal	OneCare	OneCare Connect	Active Status Date	Date Training Conducted	Date Training Completed	Signed Acknowledgement Received (Y/N)	Comments/Explanation of Missed Deadline(s)

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Policy:	EE.1103Δ
Title:	**Provider Education and Training**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	
Effective Date:	03/01/2001
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

For 20200604 BOD Review Only

I. PURPOSE

This policy outlines the initial and ongoing training and education requirements for medical, behavioral health, and Long-Term Services and Support (LTSS) Providers, who serve CalOptima's Members participating in CalOptima's programs, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. Providers generally: CalOptima or a Health Network shall provide initial and recurring training to all contracted Providers who serve CalOptima's Members participating in CalOptima's health care programs. Additionally, CalOptima will provide training to appropriate staff of designated county agencies with which CalOptima partners. Training will include, at a minimum:

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12. Member Grievance and Appeals process;

13. Utilization Management Appeals and Provider dispute resolution process; and

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19. Model of Care;

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1. Individuals covered by this requirement include, but are not limited to, CalOptima and Health Network staff, contracted CalOptima and Health Network PCPs, Practitioners, high-volume specialists, and speech, occupational, and physical therapists, in accordance with Medi-Cal Managed Care Division (MMCD) All Plan Letter 11-010 and Welfare and Institutions Code, section 14182(b)(5).

D. CalOptima or Health Networks shall also provide and disseminate additional ongoing training for contracted Providers:

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2. When conducting **Provider** forums, meetings, outreach visits;

3. When determined necessary;

4. Upon request from Providers; and

5. When CalOptima or one of its regulators determines that a Provider has discriminated against a CalOptima Member.

E. CalOptima shall educate all CalOptima Direct and CalOptima Community Network contracted **Providers**. All **Health Networks** shall educate their contracted **Providers**, in accordance with DHCS and CMS requirements.

F. CalOptima or a Health Network shall retain training records for a period of at least ten (10) years.

III. PROCEDURE

A. Initial and Recurring Training for Contracted Medical, Behavioral Health, and LTSS Providers

1. CalOptima or a Health Network shall conduct training for a newly contracted medical, behavioral health, or LTSS Provider within ten (10) business days from the Provider's placement on Active Status.

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2. CalOptima or a Health Network, as necessary, shall make a Provider Manual accessible to all contracted medical, behavioral health, and LTSS Providers. The Provider Manual shall include, at a minimum, the following information:

    a. Updates and revisions;

    b. Overview and Model of Care;

    c. CalOptima or Health Network contact information;

    d. Member benefits covered by CalOptima;

    e. Eligibility determination and verification process;

    f. Quality improvement for health services programs;

    g. Member rights and responsibilities;

    h. Provider billing and reporting;

    i. The Member problem resolution processes;

    j. The authorization process;

    k. Provider cultural and linguistic requirements;

    l. Regulatory and contractual requirements; and

    m. Other activities and services needed to assist Members in optimizing their health status, including assistance with self-management skills or techniques, health education, and other modalities to improve health status.

3. CalOptima or a Health Network shall complete training no later than thirty (30) calendar days from the Provider's placement on Active Status.

4. Upon completion of the training, the Provider shall sign an acknowledgement notice and shall return the signed acknowledgement notice to CalOptima or the Health Network.

5. If CalOptima or a Health Network is unable to complete the training within the thirty (30) calendar day requirement, CalOptima or Health Network shall send materials to the Provider's office, and document reasons and actions taken due to non-completion of the education.

6. CalOptima and its Health Networks shall track completion of the Provider's education, including the date of completion of the education.

7. A Health Network shall submit a completed Health Network Newly Contracted Provider Office Training Report to CalOptima on a quarterly basis, on or before the twenty-fifth (25th) day of the month, following the end of the quarter. If the twenty-fifth (25th) day falls on a non-business day, the Health Network shall submit the report no later than the next business day.

8. Health Networks shall provide written confirmation that appropriate Health Network staff have been educated and trained, in accordance with the DHCS cultural awareness and sensitivity instructions for SPDs.

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IV. ATTACHMENT(S)

A. Health Network Newly Contracted Provider and Practitioner Office Training Form

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
D. Department of Health Care Services (DHCS) All Plan Letter 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities
E. Title 42, Code of Federal Regulations (CFR), §§ 438.3(u), 438.206(c)(2), 438.236(c), and 438.414
F. Welfare and Institutions (W&I) Code, §14182 (b) (5)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/29/2010	Department of Health Care Services (DHCS)
02/24/2013	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2001	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	07/01/2007	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	01/01/2009	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	11/01/2012	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	03/01/2015	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2015	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	08/01/2016	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2017	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	03/07/2019	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE

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For 20200604 BOD Review Only

IX. GLOSSARY

Term	Definition
Active Status	A Provider's, PCP's, and Practitioner's contract effective date with CalOptima, a Health Network or physician group. Active status for a Provider, PCP and/or Practitioner added to a contracted medical group shall be the date the PCP and/or Practitioner is approved to provide services to Members within that group.
Appeal	Medi-Cal: A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a Covered Service. Includes a request for a fair hearing in accordance with California Code or Regulations (CCR) Titled 22, Section 51014 and Welfare and Institutions Code section 10950. OneCare and 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.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Chronic Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Critical Incident	Critical incident refers to any actual, or alleged, event, or situation, that creates a significant risk of substantial harm to the physical or mental health, safety, or well-being of a Member.
Grievance	Medi-Cal: An expression of dissatisfaction about any matter other than an adverse benefit determination. OneCare and OneCare Connect: Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action. PACE: A complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of Participant care.
Health Homes Program	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP Services that provide supplemental services to eligible Members coordinating the full

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Term	Definition
	range of physical health, behavioral health, and community-based MLTSS needed for chronic conditions.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. In-Home Supportive Services (IHSS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.
Member	An enrollee-beneficiary of a CalOptima program.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).
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.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.
Threshold Language	Medi-Cal/OneCare Connect: Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA). OneCare: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.
Whole Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole

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Term	Definition
	child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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CalOptima
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Health Network Newly Contracted Provider Office Education Report

Due Date: Before the twenty-fifth (25th) day of the month following the end of each quarter.

Health Network Name:
Year:
Quarter:
Prepared by:
Phone#:

As required by CalOptima policy EE.1103, Provider Education and Training, a health network shall:
1) Conduct training for newly contracted medical, behavioral or LTSS providers within ten (10) business days from the provider's placement on active status.
2) Complete training no later than thirty (30) calendar days from the provider's placement on active status.
3) Obtain a signed acknowledgement notice from the provider.

For Columns C, D and E, indicate the line of business with X or N/A if not applicable.

Provider Name	NPI	Medi-Cal	OneCare	OneCare Connect	Active Status Date	Date Training Conducted	Date Training Completed	Signed Acknowledgement Received (Y/N)	Comments/Explanation of Missed Deadline(s)

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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
19. Approve Revised CalOptima Policies AA. 1204: Gifts, Honoraria, and Travel Payments and AA. 1216: Solicitation and Receipt of Gifts to CalOptima

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

Recommended Action
Approve revised CalOptima Policies:
1. AA. 1204: Gifts, Honoraria, and Travel Payments; and
2. AA. 1216: Solicitation and Receipt of Gifts to CalOptima

Background
As a local public agency, CalOptima is subject to Political Reform Act (PRA) and to the jurisdiction of the Fair Political Practices Commission (FPPC). Regulations adopted by the FPPC set standards and disclosure requirements related to gifts, honoraria and travel payments made to CalOptima employees and officials by third parties. As a county-organized health system, CalOptima is also subject to Federal Anti-Kickback Statutes. To ensure compliance with these requirements, and transparency and impartiality in the conduct of official business, CalOptima maintains administrative policies to provide guidance to employees and other officials governing permissible and ethical conduct.

CalOptima reviews its Administration Policies from time to time to incorporate changes in the law, to reflect changes in business practices, and to provide additional structure and clarity. Proposed updates have been made to CalOptima Policies AA. 1204: Gifts, Honoraria, and Travel Payments and AA. 1216: Solicitation and Receipt of Gifts to CalOptima (collectively, "Gift Policies").

Discussion
The following Administrative policies have been updated and are presented for board review and approval.

AA. 1204: Gifts, Honoraria, and Travel Payments
This policy governs the limits to, and disclosure requirements of gifts, honoraria and travel payments received by individual officers or employees. The changes are summarized as follows:
- Updates to the language to correspond with the FPPC regulations;
- Added language to reflect prohibitions under the Federal Anti-Kickback Statute;
- Inclusion of some common exceptions to the prohibitions to provide better guidance for CalOptima employees and officials;
- Incorporation of suggested gift prohibitions to put CalOptima employees and officials on notice of some common types of gifts that should probably not be accepted by employees and officials, along with common exceptions;
- Revised gift limit from $25 to $5 to be consistent with prior board action related to CalOptima's Conflict of Interest Policy;

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- Suggested definitions to highlighted terms; and
- Addition of some language to the Procedures section, which was previously left blank.

AA. 1216: Solicitation and Receipt of Gifts to CalOptima

This Policy sets forth criteria, procedures and disclosure requirements for gifts received by CalOptima from outside sources, including the reporting of payments made to CalOptima that would otherwise constitute gifts to public officials, and the receipt and distribution of tickets and passes. The changes are summarized as follows:

- Suggested policy statement regarding the expectation of Employees in conducting CalOptima business;
- Reference to CalOptima Policy AA. 1204: Gifts, Honoraria, and Travel Payments for personal gifts.
- Suggested language to address consumable and non-consumable gifts with recommendations on a dollar threshold to address consumable gifts made to CalOptima.
- Updates to the language to correspond with the FPPC regulations, particularly with respect to tickets or passes and information required to report Gifts;
- Addition of some language to the Procedures section regarding the reporting requirements under the FPPC for donations and tickets to the organization.
- Removal of two attachments that cannot be located and addition of two attachments for FPPC reporting;
- Added prohibitions under the Federal Anti-Kickback Statute;
- Added language governing donations of real property;
- Added language governing gifts that can be displayed in public areas;
- Updates to the statutory references; and
- Suggested definitions for the identified terms.

Fiscal Impact

The recommended action to revise CalOptima Policies AA.1204 and AA.1216 is operational in nature and is not anticipated to have any fiscal impact.

Rationale for Recommendation

Approval is recommended of the updated Gift Policies to clarify the obligations and requirements under applicable laws, including, the Political Reform Act and Federal Anti-Kickback Statutes, governing the solicitation and receipt of gifts by CalOptima and its employees and officials, and to establish a process for the distribution of tickets or passes.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Revised CalOptima Policies:
   a. AA. 1204: Gifts, Honoraria, and Travel Payments (redlined and clean copy); and
   b. AA. 1216: Solicitation and Receipt of Gifts to CalOptima with attachments (redlined and clean copy)

Authorized Signature **Date**

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Policy:	AA.1204
Title:	**Gifts, Honoraria, and Travel Payments**
Department:	CalOptima Administrative
Section:	Legal Affairs
Interim CEO Approval:	
Effective Date:	01/10/1996
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

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I. PURPOSE

~~To ensure~~This policy ensures that CalOptima Employees and officials comply with established legal and ethical limits to avoid any Conflict of Interest, when offered an Honorarium, Gift, or Travel Payment from any outside source.

II. POLICY

A. Prohibition on Receipt of Honoraria

1. A CalOptima Employee or official (designated or non-designated) shall not accept an Honorarium in connection with his or her responsibilities at CalOptima.

2. ~~An honorarium, as used in this policy, means any payment made in consideration for any speech given, article published,~~If a CalOptima Employee or official is offered an Honorarium from any source, he or she shall decline the offer, but may suggest that the donor present the Honorarium to the CalOptima general fund as a donation within thirty (30) days after receipt.

3. The following forms of compensation are not considered Honoraria and must be reported as income on a designated Employee's Form 700 Statement of Economic Interests:

   a. Income earned from personal services in connection with an Employee's bona fide business, trade, or profession; and

   ~~a.~~b. Compensation for speeches, conference attendance, publication of articles, or attendance at any public or private conference, convention, meeting, social event, meal, or like gathering~~, that is connected to an employee's or official's responsibilities at CalOptima~~ in connection with an Employee's bona fide profession.

~~1. If a CalOptima employee or official is offered an honorarium from a source specified in the CalOptima Conflict of Interest Code, he or she shall decline the offer, but may suggest that the donor present the honorarium to the CalOptima general fund as a donation. Such a payment, when made directly to CalOptima and without reference to an employee or official, makes it an exception to being considered an honorarium.~~

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4. ~~The following forms of compensation are not considered honoraria and must be reported as income on a designated employee's Form 730 Statement of Economic Interests. (For additional~~Additional exceptions to the definition of ~~honorarium, see~~Honorarium are included under Title 2, California Code of Regulations, Sections 18930 through ~~18935~~18933, and ~~18950 through~~18950.3.) ~~may include, but re not limited to:~~

a. ~~Income earned from personal services in connection~~Information materials;

b. Campaign contributions;

~~a.~~ Personalized plaque or trophy with an ~~employee's bona fide profession; and~~

~~b. Compensation for speeches, conference attendance, publication~~individual value of ~~articles, per diem payments at board meetings or meetings of other public entities, etc., in connection with an employee's bona fide profession.~~

~~A. Prohibition on Receipt of Gifts Greater~~less than ~~twenty-five~~two hundred fifty dollars ($~~25.00) per calendar year~~

~~a.~~c. ~~A CalOptima employee~~250); or ~~official (designated or non-designated) shall not accept a gift totaling more than twenty-five dollars ($25.00) in a calendar year from any single source specified for disclosure in the CalOptima Conflict of Interest Code.~~

~~1. For purposes of this policy, a gift is any payment or other benefit given to a CalOptima employee or official for which the employee or official does not provide goods or services of equal or greater value. The following items are not considered gifts (for additional exceptions to the definition of gift, see Title 2, California Code of Regulations, Sections 18940 through 18946.5):~~

~~b. Items that are returned to the donor within thirty (30) days after receipt without being used;~~

~~a. Items that are given directly to CalOptima; and~~

~~b. Items that are given to an employee or official and donated within thirty (30) days after receipt to CalOptima.~~

~~B. Travel Payment Exceptions to the Honoraria and Gift Prohibitions~~

~~1. Exceptions apply to the gift and honoraria prohibition for certain types of travel. (For a full listing of all exceptions, see Title 2, California Code of Regulations, Sections 18950 through 18950.4).~~

~~2. The following types of travel payments are not subject to any limit and are not reportable on a Statement of Economic Interests:~~

~~a. Transportation within Orange County provided to a CalOptima employee or official directly in connection with an event at which the employee or official gives a speech, participates in a panel or seminar, or provides a similar service.~~

~~b.~~ Free admission, and refreshments~~,~~ and similar non-cash nominal benefits provided ~~to a CalOptima employee or official~~ during the entire event ~~(inside or outside of Orange County)~~ at which the ~~employee~~Employee or ~~official~~officer gives a speech, participates in a panel or seminar, ~~performs an audit,~~ or provides a similar service~~.~~

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~~c.~~d. ~~Necessary~~, and actual intrastate transportation and any necessary lodging and subsistence ~~(inside or outside Orange County),~~provided directly in connection with the speech, panel, seminar, or service, including but not limited to meals and beverages~~, provided to the employee directly in connection with an event at which the employee gives a speech, participates in a panel or seminar, or provides a similar service. The exception for meals and beverages, however, is limited to those provided~~ on the day of the activity.

B. Prohibition on Receipt of Gifts Greater Than Five Dollars ($5.00)

1. CalOptima Employees and officials shall not solicit or accept any personal gift, money, food, beverages, tickets, passes, special accommodations, services, favors, or the use of property or facilities, totaling more than five dollars ($5) in a calendar year from any person who the Employee or official knows, or has reason to know, is doing business with or intends to do business with CalOptima, unless an exception under applicable laws and regulations or as provided herein applies.

   a. This prohibition is not meant to preclude the acceptance of:

      i. Free attendance or participation at official or quasi-official functions in the regular course of an Employee's job responsibilities or events in which the Employee attends in a representative capacity as an Employee of CalOptima;

      ii. Free food, beverages, and/or entertainment that are part of such programs and functions; and/or

      iii. Gifts of nominal value such as promotional items in the form of calendars, key chains, scratch pads, recyclable bags, etc.

2. The following items will not be considered Gifts to an Employee or official:

   a. Items that are returned to the donor unused and without receiving anything of value in exchange for the returned gift within thirty (30) days after receipt;

   b. Items that are given to an Employee or official and donated, unused, to a 501(c)(3) charitable organization within thirty (30) days after receipt.

3. Additional regulations governing Gifts, including exceptions, are included under Title 2, California Code of Regulations, sections 18940 through 18946.5.

~~5.~~ Pursuant to the Federal Anti-Kickback Statute, a CalOptima Employee or official (designated or non-designated) shall not solicit or receive any gift or remuneration of any amount (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.

C. Travel Payment Exceptions to the Honoraria and Gift Prohibitions

1. Payments, advancements or reimbursements for travel, including actual transportation and related lodging and subsistence, that is reasonably related to a legislative or governmental purpose may be an exception to the Gift and Honoraria prohibition.

2. The following types of Travel Payments are not subject to any limit and are not reportable on a Statement of Economic Interests Form 700:

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a. Travel payments provided to a CalOptima Employee or official by CalOptima or by any state, local, or federal government agency which would be considered income;

b. Travel provided to the Employee or official in a vehicle or aircraft owned by another Employee, official or agency when each Employee or official is traveling to or from the same location for an event as a representative of their respective offices; or

c. Travel payments limited to the duration necessary to accomplish the purposes for which the travel was provided, made in conjunction with official CalOptima business in lieu of using CalOptima funds if the following applies to the payment:

i. Used for official agency business, with the agency deciding who will do the traveling, where the official agency business is to:

a) Fulfill a contract term that requires the contracting party to pay any expenses associated with any CalOptima travel resulting from CalOptima's participation in the contract and payment is used for that purpose;

b) Perform regulatory inspections or auditing function that CalOptima is mandated to perform;

c) Provide training or educational information directly related to the duties of CalOptima;

d) Attend educational conference directly related to CalOptima's functions or duties where the Employee or official is a named presenter at the conference and the payment is made by the organizers of the event;

e) Receive training directly related to an Employees or official's duties;

f) Participate in a working group meeting in which food is provided to all attendees of the work group and the Employee or official participates as a representative of CalOptima under officially assigned job duties; or

g) View an operation, structure, or facility to help make a decision whether to enter into a contract regarding a similar operation.

ii. Made directly to CalOptima or by making arrangements with CalOptima to make payments directly to the transportation or lodging providers and not made to the employee using the travel;

iii. Provide no personal benefit to the individual who uses the payment; and

iv. Reported by CalOptima on a Form 801.

~~1.~~3. The following types of Travel Payments are not subject to any limits but must be reported on a designated Employee's Statement of Economic Interests Form 700:

a. Travel within the United States that is reasonably related to a legislative or governmental purpose or to an issue of state, national, or international public policy, and in connection with an event at which the designated Employee gives a speech, participates in a panel ~~or seminar~~, or makes a substantive formal presentation at a seminar or ~~provides~~ similar ~~service~~event. Lodging and subsistence expenses in this case are limited to the day

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immediately preceding, the day of, and the day immediately following the speech, panel, or presentation~~other service~~.

b. Travel that is reasonably necessary in connection with a bona fide business, trade, or profession, and which satisfies the criteria for federal income tax deductions for business expenses specified in Sections 162 and 274 of the Internal Revenue Code. For reporting purposes, these Travel Payments would be considered part of the salary, wages, and other income received from the business entity ~~and would be reported on Schedule D of Form 730~~.

~~2.~~4. Additional regulations governing Travel expenses, including a full listing of all exceptions, are included under Government Code section 89506 and Title 2, California Code of Regulations, Sections 18950 through 18950.4.

III. PROCEDURE

A. Consistent with all applicable laws and CalOptima policies, designated Employees and officials shall report all gifts and income annually on the Statement of Economic Interest Form 700. All Employees (designated and non-designated) are required to submit a completed CalOptima Supplement to Form 700 upon hire and annually.

B. The Clerk of the Board shall report all Gifts and Ticket donations to CalOptima in accordance with CalOptima Policy AA.1216: Solicitation and Receipt of Gifts to CalOptima.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. ~~A.~~ CalOptima Conflicts of Interest Code
B. ~~B.~~ CalOptima Policy GA.8012: Conflicts of Interest
C. ~~C.~~ California Code of Regulations, Title 2, Sections 18930 through 18961 (Honoraria, Gifts, Travel Payments)
D. ~~D.~~ California Government Code, Sections ~~81000~~ 89500 through ~~91014~~89506
~~D.~~E. ~~E.~~ Title 42, United States Code, Section 1320a-7b(b)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/10/1996	AA.1204	Gifts, Honoraria, and Travel Payments	Administrative
Revised	10/01/1998	AA.1204	Gifts, Honoraria, and Travel Payments	Administrative
Revised	07/01/2007	AA.1204	Gifts, Honoraria, and Travel Payments	Administrative

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Action	Date	Policy	Policy Title	Program(s)
Revised		AA.1204	Gifts, Honoraria, and Travel Payments	Administrative

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IX. GLOSSARY

Term	Definition
Conflict of Interest	A situation in which a person is in a position to derive personal benefit from actions or decisions made in his/her official capacity.
Employee	For purposes of this policy, includes, but is not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, interns, CalOptima Board members, and applicable contractors and consultants.
Gift	For purposes of this policy, a gift is any payment or other benefit given to a CalOptima employee or official for which the employee or official does not provide goods or services of equal or greater value.
Honorarium/Honoraria	An honorarium, as used in this policy, means any payment made in consideration for any speech given, article published, or attendance at any public or private conference, convention, meeting, social event, meal, or like gathering, that is connected to an employee's or official's responsibilities at CalOptima.
Travel Payment	Payments, advances, or reimbursements for travel, including actual transportation and related lodging and subsistence that is reasonably related to an Employee's or official's responsibilities at CalOptima.

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Policy:	AA.1204
Title:	**Gifts, Honoraria, and Travel Payments**
Department:	CalOptima Administrative
Section:	Legal Affairs
Interim CEO Approval:	
Effective Date:	01/10/1996
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

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I. PURPOSE

This policy ensures that CalOptima Employees and officials comply with established legal and ethical limits to avoid any Conflict of Interest, when offered an Honorarium, Gift, or Travel Payment from any outside source.

II. POLICY

A. Prohibition on Receipt of Honoraria

1. A CalOptima Employee or official (designated or non-designated) shall not accept an Honorarium in connection with his or her responsibilities at CalOptima.

2. If a CalOptima Employee or official is offered an Honorarium from any source, he or she shall decline the offer, but may suggest that the donor present the Honorarium to the CalOptima general fund as a donation within thirty (30) days after receipt.

3. The following forms of compensation are not considered Honoraria and must be reported as income on a designated Employee's Form 700 Statement of Economic Interests:

   a. Income earned from personal services in connection with an Employee's bona fide business, trade, or profession; and

   b. Compensation for speeches, conference attendance, publication of articles, or attendance at any public or private conference, convention, meeting, social event, meal, or like gathering in connection with an Employee's bona fide profession.

4. Additional exceptions to the definition of Honorarium are included under Title 2, California Code of Regulations, Sections 18930 through 18933, and may include, but re not limited to:

   a. Information materials;

   b. Campaign contributions;

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c. Personalized plaque or trophy with an individual value of less than two hundred fifty dollars ($250); or

d. Free admission, and refreshments and similar non-cash nominal benefits provided during the entire event at which the Employee or officer gives a speech, participates in a panel or seminar, or provides a similar service, and actual intrastate transportation and any necessary lodging and subsistence provided directly in connection with the speech, panel, seminar, or service, including but not limited to meals and beverages on the day of the activity.

B. Prohibition on Receipt of Gifts Greater Than Five Dollars ($5.00)

1. CalOptima Employees and officials shall not solicit or accept any personal gift, money, food, beverages, tickets, passes, special accommodations, services, favors, or the use of property or facilities, totaling more than five dollars ($5) in a calendar year from any person who the Employee or official knows, or has reason to know, is doing business with or intends to do business with CalOptima, unless an exception under applicable laws and regulations or as provided herein applies.

a. This prohibition is not meant to preclude the acceptance of:

i. Free attendance or participation at official or quasi-official functions in the regular course of an Employee's job responsibilities or events in which the Employee attends in a representative capacity as an Employee of CalOptima;

ii. Free food, beverages, and/or entertainment that are part of such programs and functions; and/or

iii. Gifts of nominal value such as promotional items in the form of calendars, key chains, scratch pads, recyclable bags, etc.

2. The following items will not be considered Gifts to an Employee or official:

a. Items that are returned to the donor unused and without receiving anything of value in exchange for the returned gift within thirty (30) days after receipt;

b. Items that are given to an Employee or official and donated, unused, to a 501(c)(3) charitable organization within thirty (30) days after receipt.

3. Additional regulations governing Gifts, including exceptions, are included under Title 2, California Code of Regulations, sections 18940 through 18946.5.

Pursuant to the Federal Anti-Kickback Statute, a CalOptima Employee or official (designated or non-designated) shall not solicit or receive any gift or remuneration of any amount (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.

C. Travel Payment Exceptions to the Honoraria and Gift Prohibitions

1. Payments, advancements or reimbursements for travel, including actual transportation and related lodging and subsistence, that is reasonably related to a legislative or governmental purpose may be an exception to the Gift and Honoraria prohibition.

2. The following types of Travel Payments are not subject to any limit and are not reportable on a Statement of Economic Interests Form 700:

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a. Travel payments provided to a CalOptima Employee or official by CalOptima or by any state, local, or federal government agency which would be considered income;

b. Travel provided to the Employee or official in a vehicle or aircraft owned by another Employee, official or agency when each Employee or official is traveling to or from the same location for an event as a representative of their respective offices; or

c. Travel payments limited to the duration necessary to accomplish the purposes for which the travel was provided, made in conjunction with official CalOptima business in lieu of using CalOptima funds if the following applies to the payment:

i. Used for official agency business, with the agency deciding who will do the traveling, where the official agency business is to:

a) Fulfill a contract term that requires the contracting party to pay any expenses associated with any CalOptima travel resulting from CalOptima's participation in the contract and payment is used for that purpose;

b) Perform regulatory inspections or auditing function that CalOptima is mandated to perform;

c) Provide training or educational information directly related to the duties of CalOptima;

d) Attend educational conference directly related to CalOptima's functions or duties where the Employee or official is a named presenter at the conference and the payment is made by the organizers of the event;

e) Receive training directly related to an Employees or official's duties;

f) Participate in a working group meeting in which food is provided to all attendees of the work group and the Employee or official participates as a representative of CalOptima under officially assigned job duties; or

g) View an operation, structure, or facility to help make a decision whether to enter into a contract regarding a similar operation.

ii. Made directly to CalOptima or by making arrangements with CalOptima to make payments directly to the transportation or lodging providers and not made to the employee using the travel;

iii. Provide no personal benefit to the individual who uses the payment; and

iv. Reported by CalOptima on a Form 801.

3. The following types of Travel Payments are not subject to any limits but must be reported on a designated Employee's Statement of Economic Interests Form 700:

a. Travel within the United States that is reasonably related to a legislative or governmental purpose or to an issue of state, national, or international public policy, and in connection with an event at which the designated Employee gives a speech, participates in a panel, or makes a substantive formal presentation at a seminar or similar event. Lodging and

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subsistence expenses in this case are limited to the day immediately preceding, the day of, and the day immediately following the speech, panel, or presentation.

b. Travel that is reasonably necessary in connection with a bona fide business, trade, or profession, and which satisfies the criteria for federal income tax deductions for business expenses specified in Sections 162 and 274 of the Internal Revenue Code. For reporting purposes, these Travel Payments would be considered part of the salary, wages, and other income received from the business entity.

4. Additional regulations governing Travel expenses, including a full listing of all exceptions, are included under Government Code section 89506 and Title 2, California Code of Regulations, Sections 18950 through 18950.4.

III. PROCEDURE

A. Consistent with all applicable laws and CalOptima policies, designated Employees and officials shall report all gifts and income annually on the Statement of Economic Interest Form 700. All Employees (designated and non-designated) are required to submit a completed CalOptima Supplement to Form 700 upon hire and annually.

B. The Clerk of the Board shall report all Gifts and Ticket donations to CalOptima in accordance with CalOptima Policy AA.1216: Solicitation and Receipt of Gifts to CalOptima.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Conflicts of Interest Code
B. CalOptima Policy GA.8012: Conflicts of Interest
C. California Code of Regulations, Title 2, Sections 18930 through 18961 (Honoraria, Gifts, Travel Payments)
D. California Government Code, Sections 89500 through 89506
E. Title 42, United States Code, Section 1320a-7b(b)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/10/1996	AA.1204	Gifts, Honoraria, and Travel Payments	Administrative
Revised	10/01/1998	AA.1204	Gifts, Honoraria, and Travel Payments	Administrative
Revised	07/01/2007	AA.1204	Gifts, Honoraria, and Travel Payments	Administrative
Revised		AA.1204	Gifts, Honoraria, and Travel Payments	Administrative

For 20200604 BOD Review Only

IX. GLOSSARY

Term	Definition
Conflict of Interest	A situation in which a person is in a position to derive personal benefit from actions or decisions made in his/her official capacity.
Employee	For purposes of this policy, includes, but is not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, interns, CalOptima Board members, and applicable contractors and consultants.
Gift	For purposes of this policy, a gift is any payment or other benefit given to a CalOptima employee or official for which the employee or official does not provide goods or services of equal or greater value.
Honorarium/Honoraria	An honorarium, as used in this policy, means any payment made in consideration for any speech given, article published, or attendance at any public or private conference, convention, meeting, social event, meal, or like gathering, that is connected to an employee's or official's responsibilities at CalOptima.
Travel Payment	Payments, advances, or reimbursements for travel, including actual transportation and related lodging and subsistence that is reasonably related to an Employee's or official's responsibilities at CalOptima.

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Policy:	AA.1216
Title:	**Solicitation and Receipt of Gifts to CalOptima**
Department:	CalOptima Administrative
Section:	Legal Affairs
Interim CEO Approval:	
Effective Date:	10/01/1998
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20200604 BOD Review Only

I. PURPOSE

~~To define~~This policy defines the criteria and procedure for ~~CalOptima to solicit or receive gifts~~Gifts received from outside sources, in accordance with the Political Reform Act~~.~~ and the Federal Anti-Kickback Statute.

II. POLICY

A. CalOptima Employees and officials are expected to conduct business and provide services in an impartial manner, and the acceptance of gifts, money, or gratuities from any person or organization is prohibited except as provided herein.

~~A.~~B. Donations and/or Gifts given to CalOptima shall be used only for official CalOptima business, in a way that is compatible with CalOptima's purpose and mission, and in the ordinary course of CalOptima's business.

1. Gifts that are consumable or usable in the common work areas with a fair market value of under $50 may be accepted by a department director after providing notice and information to the Clerk of the Board with the condition that the Gifts remain on the premises to be enjoyed by all employees in the department or floor.

2. Subject to the discretion of the Chief Executive Officer, gifts that are consumable with a fair market value of $50 or more, or that are not consumable on the premises shall be returned to the gift giver, donated to CalOptima for use by an employee program (e.g., Biggest Loser, Walk Across America, etc.) or as a door prize at a CalOptima sponsored event, or donated to a community non-profit organization.

3. CalOptima may accept items that can be displayed in public areas of CalOptima's buildings (such as flowers, art, sculptures, photographs, plaques, trophies, etc.).

~~B.~~C. Projects funded ~~by gifts~~in whole or in part by Gifts from outside entities shall not interfere, alter, or redirect the ongoing business of CalOptima.

~~C.~~D. ~~A~~ Designated Gifts where the donor ~~may identify a~~ specifies the specific purpose for CalOptima's use of ~~a gift. However,~~the Gift may only be accepted when the purpose is consistent

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with CalOptima's goals and objectives and is in the best interest of CalOptima. CalOptima shall consider the public trust and exercise sole discretion in determining the use of a Gift, including the designation of specific staff to utilize the Gift.

D.E. CalOptima shall not explicitly or implicitly endorse a commercial product, vendor, or service (e.g., pharmaceuticals or health care products).

E.F. Gifts may be solicited or received only for projects that benefit Members. Special projects may include, but are not limited to, research initiatives, enhancement programs, educational programs, or support services for Members, Providers, Practitioners, partnerships, and other related activities.

F.G. CalOptima shall not solicit Gifts for projects or services normally required in managed care operations, or for projects that are required by the CalOptima's contract with the Department of Health Care Services and that are accounted for in the CalOptima annual budget.

H. CalOptima shall not solicit or receive any Gift or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind:

1. In return for referring an individual or individuals to a person or business reimbursable under the Medi-Cal or Medicare programs; or

2. In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any good, facility, service, or item reimbursable under the Medi-Cal or Medicare programs.

G.I. Monetary Gifts shall be payable to CalOptima, and shall be deposited in CalOptima's general fund or other fund established for a special project. Gifts or donations with restrictions shall be segregated into a separate account to ensure that any limitation on or use of the received funds will be met and such compliance will be verified.

J. The acceptance of any giftAny Gift or donation of real property or any estate in real property may only be accepted pursuant to applicable state law, including, but not limited to, the requirement of a resolution of acceptance passed by the governing body pursuant to Government Code section 27281.

K. Tickets or passes received by CalOptima or any CalOptima Employee or official, whether complimentary or paid for by CalOptima, that provide admission to a facility or event for an entertainment, amusement, recreational or similar purpose may not be accepted or used by an Employee except as provided below:

1. The distribution shall be made solely to accomplish a public purpose as follows:

a. Involvement of a CalOptima Employee or official in a noteworthy community event to reflect CalOptima's support and involvement in community, non-governmental and governmental events;

b. To educate members of the community regarding CalOptima's interests, operation, organization or community activities in fulfilling CalOptima's mission;

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c. To promote CalOptima or CalOptima sponsored or supported community programs and/or resources;

d. To demonstrate CalOptima's support for events that are socially or community oriented;

e. To support cultural, local, State, and national holidays, celebrations and similar festivals; or

f. To promote and support Employee morale, retention or to reward public service.

2. Tickets or passes distributed to Employees pursuant to this Policy may not be sold or transferred to any other person, except to other CalOptima Employees or members of the Employee's immediate family. Tickets should be returned to CalOptima for redistribution if the Employee does not intend to use them.

3. The distribution requirements do not apply to a single ticket provided to and used by a CalOptima Employee or official to an event at which the Employee or official performs a ceremonial role or function on behalf of CalOptima. Such use shall be reported to the Clerk of the Board to ensure CalOptima complies with the posting and disclosure requirements under applicable laws.

~~H.~~L. The acceptance of any personal Gift by a designated CalOptima officer or employee is governed by CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments. ~~In some instances, such as when the mandates of this policy are not followed, payments which appear to be gifts to CalOptima could result in the making of a gift to a designated officer or employee.~~ A gift includes any payment or other benefit provided to an individual for which the individual does not provide goods or services of equal or greater value. A gift includes a rebate or discount in the price of anything of value unless the rebate or discount is made in the regular course of business to members of the public. (See Government Code section 82028.)

M. In some instances, such as when the mandates of this Policy are not followed, Payments which appear to be Gifts to CalOptima could result in the making of a reportable Gift to a designated officer or employee.

N. Any Gift or donation that fails to meet the guidelines set forth herein shall be returned to the donor unused within a reasonable period of time.

III. PROCEDURE

A. ~~Each gift shall be~~Each Gift shall be reported to the Clerk of the Board on the Gift Tracking Form within five (5) business days and documented in the CalOptima Gift Record within thirty (30) days after receipt. The Clerk of the Board of Directors shall be responsible for maintaining CalOptima's Gift Record and shall make it available to the public upon request, pursuant CalOptima Policy AA.1215: Public Records Requests~~.~~ and Subpoenas.

1. The Gift Record shall consist of a CalOptima Gift Tracking Form and shall contain the following information:

a. Name and address of the donor;

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b. ~~Value nature of the gift~~If the donor is not an individual, the business or organization name and address;

~~b.~~c. Description of the Gift and actual or estimated fair market value of the Gift or services provided (e.g., cash donation or other);

d. Intended purpose of the Gift;

~~c.~~e. Official CalOptima use of the ~~gift~~Gift, and the name, title, and department of the Employee(s) who used the Gift;

~~d.~~f. Date that CalOptima received the ~~gift~~Gift;

~~e. Specific employee benefiting from or using the gift (if applicable); and~~

~~f.~~g. Date that ~~gift~~Gift was filed in Gift Record.

2. The Clerk of the Board of Directors shall submit, post and disclose all Gifts made to CalOptima for use by CalOptima Employees or officials on the appropriate Fair Political Practices Committee (FPPC) form based on the nature of the Gift within thirty (30) days after the close of the quarter. Unless otherwise required, Gifts made to CalOptima for CalOptima's programs will not need to be included in the FPPC form.

~~2.~~3. The Clerk of the Board of Directors shall provide a quarterly report to the Chief Executive Officer and the Chief Financial Officer of all Gifts received during that period.

B. All entities seeking to donate a Gift to CalOptima shall contact CalOptima's Communications Department.

C. CalOptima's Communications Department is authorized to make initial contacts to potential donors regarding solicitation of Gifts.

D. CalOptima staff seeking funds for special projects shall contact CalOptima's Communications Department.

~~I. ATTACHMENTS~~

~~A. Gift Request Form~~
~~B. Requests for Projects Funded by Grants~~

E. Tickets or passes donated to CalOptima may not be earmarked by any outside source for use by a specific CalOptima Employee or official. CalOptima shall have absolute discretion on who uses the ticket or pass or how it will be distributed. CalOptima's CEO shall have authority to determine the public purpose and method of distribution of any ticket or pass to Employees or officials.

1. Within forty-five (45) days of distribution of a ticket or pass, the Clerk of the Board must report the following on the appropriate FPPC form:

a. The name of the Employee or official receiving the ticket or pass;

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b. A description of the event;

c. The date of the event;

d. The fair value of the ticket or pass;

e. The number of tickets or passes provided to each person; and

f. A description of the public purpose under which the distribution was made.

IV. ATTACHMENT(S)

~~C.~~A. Gift Tracking Form
B. FPPC Form 801 (Gifts and Donations)
C. FPPC Form 802 (Tickets and Passes)

~~IV.~~V. REFERENCE(S)

A. CalOptima Policy AA.1001: Glossary of Terms
B. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
~~C. CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo~~
~~D.~~C. CalOptima Policy AA.1215: Public Records Requests and Subpoenas
~~E.~~D. California Government Code, Section 82028~~(a)~~
~~F.~~E. Title 2, California Code of Regulations, Section ~~18944.2~~18940, *et seq.*

F. ~~**APPROVALS OR**~~ Title 42, United States Code Section 1320a-7b(b)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

~~V.~~VII. BOARD ACTION(S)

~~Not Applicable~~

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

~~VI.~~VIII. REVISION HISTORY

~~7/1/07: AA.1216: Solicitation and Receipt of Gifts~~
~~10/1/98: AA.1216: Solicitation and Receipt of Gifts~~

~~II. KEYWORDS~~

~~Gifts~~
~~Receipt~~
~~Solicitation~~

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Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1998	AA.1216	Solicitation and Receipt of Gifts	Administrative
Revised	07/01/2007	AA.1216	Solicitation and Receipt of Gifts	Administrative
Revised	11/01/2013	AA.1216	Solicitation and Receipt of Gifts	Administrative
Revised		AA.1216	Solicitation and Receipt of Gifts	Administrative

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IX. GLOSSARY

Term	Definition
Gift	For purposes of this policy, a gift is any payment, service or other benefit given to CalOptima for which CalOptima does not provide goods or services of equal or greater value.
Member	A beneficiary who is enrolled in a CalOptima program.
Payment	A payment, distribution, transfer, loan, advance, deposit, gift or other rendering of money, property, services or anything else of value, whether tangible or intangible, including the payment for, or provision of, fees, goods or services to CalOptima where the person providing the payment has no legal obligation to do so.
Provider	All contracted Providers including physicians, ancillary Providers, and Facilities.

For 20200604 BOD Review Only

Policy:	AA.1216
Title:	**Solicitation and Receipt of Gifts to CalOptima**
Department:	CalOptima Administrative
Section:	Legal Affairs
Interim CEO Approval:	
Effective Date:	10/01/1998
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20200604 BOD Review Only

I. PURPOSE

This policy defines the criteria and procedure for Gifts received from outside sources, in accordance with the Political Reform Act and the Federal Anti-Kickback Statute.

II. POLICY

A. CalOptima Employees and officials are expected to conduct business and provide services in an impartial manner, and the acceptance of gifts, money, or gratuities from any person or organization is prohibited except as provided herein.

B. Donations and/or Gifts given to CalOptima shall be used only for official CalOptima business, in a way that is compatible with CalOptima's purpose and mission, and in the ordinary course of CalOptima's business.

1. Gifts that are consumable or usable in the common work areas with a fair market value of under $50 may be accepted by a department director after providing notice and information to the Clerk of the Board with the condition that the Gifts remain on the premises to be enjoyed by all employees in the department or floor.

2. Subject to the discretion of the Chief Executive Officer, gifts that are consumable with a fair market value of $50 or more, or that are not consumable on the premises shall be returned to the gift giver, donated to CalOptima for use by an employee program (e.g., Biggest Loser, Walk Across America, etc.) or as a door prize at a CalOptima sponsored event, or donated to a community non-profit organization.

3. CalOptima may accept items that can be displayed in public areas of CalOptima's buildings (such as flowers, art, sculptures, photographs, plaques, trophies, etc.).

C. Projects funded in whole or in part by Gifts from outside entities shall not interfere, alter, or redirect the ongoing business of CalOptima.

D. Designated Gifts where the donor specifies the specific purpose for CalOptima's use of the Gift may only be accepted when the purpose is consistent with CalOptima's goals and objectives and is in the

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best interest of CalOptima. CalOptima shall consider the public trust and exercise sole discretion in determining the use of a Gift, including the designation of specific staff to utilize the Gift.

E. CalOptima shall not explicitly or implicitly endorse a commercial product, vendor, or service (e.g., pharmaceuticals or health care products).

F. Gifts may be solicited or received for projects that benefit Members. Special projects may include, but are not limited to, research initiatives, enhancement programs, educational programs, or support services for Members, Providers, partnerships, and other related activities.

G. CalOptima shall not solicit Gifts for projects or services normally required in managed care operations, or for projects that are required by CalOptima's contract with the Department of Health Care Services and that are accounted for in the CalOptima annual budget.

H. CalOptima shall not solicit or receive any Gift or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind:

1. In return for referring an individual or individuals to a person or business reimbursable under the Medi-Cal or Medicare programs; or

2. In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any good, facility, service, or item reimbursable under the Medi-Cal or Medicare programs.

I. Monetary Gifts shall be payable to CalOptima and shall be deposited in CalOptima's general fund or other fund established for a special project. Gifts or donations with restrictions shall be segregated into a separate account to ensure that any limitation on or use of the received funds will be met and such compliance will be verified.

J. Any Gift or donation of real property or any estate in real property may only be accepted pursuant to applicable state law, including, but not limited to, the requirement of a resolution of acceptance passed by the governing body pursuant to Government Code section 27281.

K. Tickets or passes received by CalOptima or any CalOptima Employee or official, whether complimentary or paid for by CalOptima, that provide admission to a facility or event for an entertainment, amusement, recreational or similar purpose may not be accepted or used by an Employee except as provided below:

1. The distribution shall be made solely to accomplish a public purpose as follows:

a. Involvement of a CalOptima Employee or official in a noteworthy community event to reflect CalOptima's support and involvement in community, non-governmental and governmental events;

b. To educate members of the community regarding CalOptima's interests, operation, organization or community activities in fulfilling CalOptima's mission;

c. To promote CalOptima or CalOptima sponsored or supported community programs and/or resources;

d. To demonstrate CalOptima's support for events that are socially or community oriented;

e. To support cultural, local, State, and national holidays, celebrations and similar festivals; or

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f. To promote and support Employee morale, retention or to reward public service.

2. Tickets or passes distributed to Employees pursuant to this Policy may not be sold or transferred to any other person, except to other CalOptima Employees or members of the Employee's immediate family. Tickets should be returned to CalOptima for redistribution if the Employee does not intend to use them.

3. The distribution requirements do not apply to a single ticket provided to and used by a CalOptima Employee or official to an event at which the Employee or official performs a ceremonial role or function on behalf of CalOptima. Such use shall be reported to the Clerk of the Board to ensure CalOptima complies with the posting and disclosure requirements under applicable laws.

L. The acceptance of any personal Gift by a designated CalOptima officer or employee is governed by CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments. A gift includes any payment or other benefit provided to an individual for which the individual does not provide goods or services of equal or greater value. A gift includes a rebate or discount in the price of anything of value unless the rebate or discount is made in the regular course of business to members of the public. (See Government Code section 82028.)

M. In some instances, such as when the mandates of this Policy are not followed, Payments which appear to be Gifts to CalOptima could result in the making of a reportable Gift to a designated officer or employee.

N. Any Gift or donation that fails to meet the guidelines set forth herein shall be returned to the donor unused within a reasonable period of time.

III. PROCEDURE

A. Each Gift shall be reported to the Clerk of the Board on the Gift Tracking Form within five (5) business days and documented in the CalOptima Gift Record within thirty (30) days after receipt. The Clerk of the Board of Directors shall be responsible for maintaining CalOptima's Gift Record and shall make it available to the public upon request, pursuant CalOptima Policy AA.1215: Public Records Requests and Subpoenas.

1. The Gift Record shall consist of a CalOptima Gift Tracking Form and shall contain the following information:

a. Name and address of the donor;

b. If the donor is not an individual, the business or organization name and address;

c. Description of the Gift and actual or estimated fair market value of the Gift or services provided (e.g., cash donation or other);

d. Intended purpose of the Gift;

e. Official CalOptima use of the Gift, and the name, title, and department of the Employee(s) who used the Gift;

f. Date that CalOptima received the Gift;

g. Date that Gift was filed in Gift Record.

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2. The Clerk of the Board of Directors shall submit, post and disclose all Gifts made to CalOptima for use by CalOptima Employees or officials on the appropriate Fair Political Practices Committee (FPPC) form based on the nature of the Gift within thirty (30) days after the close of the quarter. Unless otherwise required, Gifts made to CalOptima for CalOptima's programs will not need to be included in the FPPC form.

3. The Clerk of the Board of Directors shall provide a quarterly report to the Chief Executive Officer and the Chief Financial Officer of all Gifts received during that period.

B. All entities seeking to donate a Gift to CalOptima shall contact CalOptima's Communications Department.

C. CalOptima's Communications Department is authorized to make initial contacts to potential donors regarding solicitation of Gifts.

D. CalOptima staff seeking funds for special projects shall contact CalOptima's Communications Department.

E. Tickets or passes donated to CalOptima may not be earmarked by any outside source for use by a specific CalOptima Employee or official. CalOptima shall have absolute discretion on who uses the ticket or pass or how it will be distributed. CalOptima's CEO shall have authority to determine the public purpose and method of distribution of any ticket or pass to Employees or officials.

1. Within forty-five (45) days of distribution of a ticket or pass, the Clerk of the Board must report the following on the appropriate FPPC form:

a. The name of the Employee or official receiving the ticket or pass;

b. A description of the event;

c. The date of the event;

d. The fair value of the ticket or pass;

e. The number of tickets or passes provided to each person; and

f. A description of the public purpose under which the distribution was made.

IV. ATTACHMENT(S)

A. Gift Tracking Form
B. FPPC Form 801 (Gifts and Donations)
C. FPPC Form 802 (Tickets and Passes)

V. REFERENCE(S)

A. CalOptima Policy AA.1001: Glossary of Terms
B. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
C. CalOptima Policy AA.1215: Public Records Requests and Subpoenas
D. California Government Code, Section 82028
E. Title 2, California Code of Regulations, Section 18940, *et seq.*
F. Title 42, United States Code Section 1320a-7b(b)

VI. REGULATORY AGENCY APPROVAL(S)

For 20200604 BOD Review Only

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1998	AA.1216	Solicitation and Receipt of Gifts	Administrative
Revised	07/01/2007	AA.1216	Solicitation and Receipt of Gifts	Administrative
Revised	11/01/2013	AA.1216	Solicitation and Receipt of Gifts	Administrative
Revised		AA.1216	Solicitation and Receipt of Gifts	Administrative

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IX. GLOSSARY

Term	Definition
Gift	For purposes of this policy, a gift is any payment, service or other benefit given to CalOptima for which CalOptima does not provide goods or services of equal or greater value.
Member	A beneficiary who is enrolled in a CalOptima program.
Payment	A payment, distribution, transfer, loan, advance, deposit, gift or other rendering of money, property, services or anything else of value, whether tangible or intangible, including the payment for, or provision of, fees, goods or services to CalOptima where the person providing the payment has no legal obligation to do so.
Provider	All contracted Providers including physicians, ancillary Providers, and Facilities.

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Gift Tracking Form

DONOR INFORMATION	
Name of Donor:	**Gift Description:** **Value of Gift: $**
Address:	**Phone:** **Date Received:**

PURPOSE OF GIFT, IF ANY:

[click **here** to add text]

NATURE OF GIFT:

[click **here** to add text]

OFFICIAL USE OF GIFT: (NAME, TITLE, AND DEPARTMENT OF EMPLOYEE(S) WHO USED GIFT)

[click **here** to add text]

Name of Employee Reporting Gift:
Department:

CalOptima has received this gift and has, in its sole discretion, determined the use of the gift.

Signed by:

_____ _____

Sharon Dwiers
Clerk of the Board

Date filed in Gift Record

*Employees must complete this form and submit to the Clerk of the Board within **5** business days of receiving a Gift on behalf of CalOptima. This form must be filed in public record no later than 30 days after receipt of the gift.*

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Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT

California Form 801

For Official Use Only

Date Stamp

1. Agency Name

Division, Department, or Region (if applicable)

Street Address

Area Code/Phone Number | **Email**

Agency Contact (name and title)

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name) ☐ Other _____ (Name)

_____ (Address) _____ (City) _____ (State) _____ (Zip Code)

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

_____ (Location of Travel) _____ (Dates (month, day, year))

_____ (Transportation Provider) ☐ Rail ☐ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) _____ (Name of Lodging Facility)

$_____ (Lodging Expenses) $_____ (Meal Expenses) $_____ (Transportation Expenses) $_____ (Other Expenses) $_____ (Total Expenses)

3.1 (b) Payment(s) not related to travel:

_____ (Dates (month, day, year)) $ _____ (Total Expenses)

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

_____ (Last Name) _____ (First Name) _____ (Position/Title) _____ (Department/Division)

_____ (Last Name) _____ (First Name) _____ (Position/Title) _____ (Department/Division)

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

_____ (Signature) _____ (Print Name) _____ (Title) _____ (month, day, year)

Comment:

(Use this space or an attachment for any additional information)

Payment to Agency Report Instructions

A Public Document

California Form 801

This form is used to report certain payments received by state and local government agencies. It includes:

- a payment for an official's travel expenses for the purpose of facilitating the public's business in lieu of a payment using agency funds; and
- a payment that would otherwise be considered a gift or income to the benefiting official, but is instead accepted on behalf of the agency.

FPPC Regulations 18944 and 18950.1 provide a procedure that state and local agencies may use to disclose payments used for agency purposes and paid by a third party. The regulations' reporting procedures provide an alternative means to disclose a payment that may otherwise be considered income or a gift to a benefitting employee and subject to reporting on a Statement of Economic Interest, Form 700.

When and Where to File

An agency accepting a payment pursuant to Regulation 18944 and 18950.1 must complete Form 801 for each payment received regardless of the amount. The form must be maintained as a public document. If payments aggregate $2,500 or more in a calendar quarter, website posting is required.

Website Posting:

State Agencies
Within 30 days after the end of a calendar quarter if aggregated reported payments, for travel and non-travel purposes, total $2,500 or more:

- the agency must post the reports (or a report summary) on the agency website; and
- forward the information to the FPPC which will also post the information.

Local Agencies
The website posting rules differ for travel and non-travel payments.

Travel
Within 30 days after the end of a calendar quarter if aggregated reported payments total $2,500 or more:

- the agency must post the reports (or a report summary) on the agency website; and
- forward the information to the FPPC.

Payments Not Related to Travel
The agency's filing officer for Statement of Economic Interests, Form 700, must receive the report. Within 30 days after the end of a calendar quarter if aggregated reported payments total $2,500 or more, the local agency must post the information on the local agency website. A report is not sent to the FPPC unless the agency does not have a website.

Postings must be displayed in a prominent manner and easily accessible. Reports may be posted earlier.

FPPC: Statements should be emailed to form801@fppc.ca.gov. Statements may also be mailed to 1102 Q Street, Suite 3000, Sacramento, CA 95811 or faxed to (916) 322-3711.

Part 1. Agency Identification
List the agency's name and address and the name of an agency contact. Mark the amendment box if changing any information on a previously filed form and include the date of the original filing.

Part 2. Donor Information
Disclose the name and address of the donor. If the donor is not an individual, identify the business activity or nature and interests of the entity.

If the donor received funds from other sources that were used in connection with the payment, disclose the name and payment information for each source.

Part 3. Payment Information
Expenses may be rounded to whole dollars.

Section 3.1.a. Itemize travel payments including departure and return dates. Complete all fields, use "n/a" appropriately. Total the expenses for items such as taxi rides, gratuities, and rental cars in the "other" field and describe in the comments section.

Section 3.1.b. Report agency payments that are not travel related.

Section 3.2. Description

All payments must include a specific description of the use of the payment and the intended purpose for agency business. For example, a travel payment may read: Travel to attend an EPA co-sponsored solar energy seminar in Washington D.C.

Section 3.3. Identify Officials
Travel Payments: The name of the position/title and department of each official who used the payment is required. List the official's name if he/she is an elected or appointed official. It is not required to list the names of other officials, rather insert "n/a." Do not leave blank.

Non-Travel Payments: The name, position/title and department of the agency official who used the payment must be identified. All officials' names are required.

Part 4. Verification

Verification of travel payments must be signed by an authorized agency official. Such individuals are those who have the authority to approve similar travel payments when made with agency funds.

Verification of non-travel payments must be signed by the agency head.

Reset Page Print Form

Agency Report of: Ceremonial Role Events and Ticket/Pass Distributions

A Public Document

1. Agency Name

Date Stamp

California Form 802

For Official Use Only

Division, Department, or Region *(if applicable)*

Designated Agency Contact *(Name, Title)*

Area Code/Phone Number | **E-mail**

☐ **Amendment** *(Must Provide Explanation in Part 3.)*

Date of Original Filing: _____ *(month, day, year)*

2. Function or Event Information

Does the agency have a ticket policy? Yes ☐ No ☐

Face Value of Each Ticket/Pass $ _____

Event Description: _____ *Provide Title/ Explanation*

Date(s) ____/____/____ ____/____/____

Ticket(s)/Pass(es) provided by agency? Yes ☐ No ☐

If no: _____ *Name of Source*

Was ticket distribution made at the behest of agency official? Yes ☐ No ☐

If yes: _____ *Official's Name (Last, First)*

3. Recipients

• Use Section A to identify the agency's department or unit. • Use Section B to identify an individual. • Use Section C to identify an outside organization.

A. Name of Agency, Department or Unit	Number of Ticket(s)/ Passes	Describe the public purpose made pursuant to the agency's policy

B. Name of Individual *(Last, First)*	Number of Ticket(s)/ Passes	Identify one of the following:
		Ceremonial Role ☐ Other ☐ Income ☐ *If checking "Ceremonial Role" or "Other" describe below:*
		Ceremonial Role ☐ Other ☐ Income ☐ *If checking "Ceremonial Role" or "Other" describe below:*

C. Name of Outside Organization (include address and description)	Number of Ticket(s)/ Passes	Describe the public purpose made pursuant to the agency's policy

4. Verification

I have read and understand FPPC Regulations 18944.1 and 18942. I have verified that the distribution set forth above, is in accordance with the requirements.

Signature of Agency Head or Designee | Print Name | Title | *(month, day, year)*

Comment: _____

Agency Report of: Ceremonial Role Events and Ticket/Pass Distributions

California Form 802

A Public Document

This form is for use by all state and local government agencies. The form identifies persons that receive admission tickets and passes and describes the public purpose for the distribution. This form was prepared by the Fair Political Practices Commission (FPPC) and is available at www.fppc.ca.gov.

General Information

FPPC Regulation 18944.1 sets out the circumstances under which an agency's distribution of tickets to entertainment events, sporting events, and like occasions would not result in a gift to individuals that attend the function. In general, the agency must adopt a policy which identifies the public purpose served in distributing the admissions. The Form 802 serves to detail each event and the public purpose of each ticket distribution. FPPC Regulation 18942 lists exceptions to reportable gifts, including ceremonial events, when listed on this form.

When the regulation procedures are followed, persons, organizations, or agencies who receive admissions are listed on a Form 802. Agency officials do not report the admissions on the official's Statement of Economic Interests, Form 700, and the value of the admission is not subject to the gift limit.

The Form 802 also informs the public as to whether the admissions were made at the behest of an agency official and whether the behested tickets were provided to an organization or to specific individuals.

Exception

FPPC This form is not required for admission provided to a school or university district official, coach, athletic director, or employee to attend an amateur event performed by students of that school or university.

Reporting and Public Posting

Ticket Distribution Policies: An agency must post its ticket policy on its website within 30 days of adoption or amendment and e-mail a link of the website location to FPPC at form802@fppc.ca.gov.

Form 802: The use of the ticket or pass under the policy must be reported on Form 802 and posted on the agency's website within 45 days of distribution. A link to the website location of the forms must be e-mailed to FPPC at form802@fppc.ca.gov.

The FPPC will post on its website the link to each agency's policy and completed forms. It is not necessary to send an e-mail each time a new Form 802 is posted. It is only necessary to submit the link if the posting location changes.

This form must be maintained as a public document.

Privacy Information Notice

Information requested by the FPPC is used to administer and enforce the Political Reform Act. Failure to provide information may be a violation subject to administrative, criminal, or civil penalties. All reports are public records available for inspection and reproduction. Direct questions to FPPC's General Counsel.

Instructions

Part 1. Agency Identification:
List the agency's name. Provide a designated agency contact person, their phone number, and e-mail address. Mark the amendment box if changing any information on a previously filed form and include the date of the original filing.

Part 2. Function or Event Information:
Confirm that your agency has a policy for ticket distribution. Unless the ceremonial role or income box in Part 3, Section B, is marked, this form is only applicable if your agency has a policy.

Complete all of the other required fields that identify the ticket value, description of event, date(s) and whether the ticket was provided by the agency or an outside source. If an agency official behests the tickets, the official's name is also required. Use the comment field or an attachment to explain in full.

Part 3. Ticket Recipients:
This part identifies who uses the tickets. The identification requirements vary depending upon who received the tickets and are categorized into three sections. Each section must list the number of tickets received. Use the comment field or an attachment to explain in full.

Section A. Report tickets distributed to agency staff, other than an elected official or governing board member, pursuant to the agency's policy. It is not necessary to list each employee's name, but identify the unit/department for which the employee works. The agency must describe the public purpose associated with the ticket distribution. A reference to the policy is permissible.

Section B. Report: 1) any agency official who performs a ceremonial role; 2) any agency official who reports the value as income; or 3) tickets used by elected officials and governing board members (including those distributed pursuant to the agency's policy).

Section C. Report tickets provided to an organization. The organization's name, an address (website url is permissible), and a brief description of the public purpose are required.

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Reset Page Print Form

Agency Report of: Ceremonial Role Events and Ticket/Pass Distributions Continuation Sheet

California Form 802

A Public Document

Agency Name

3. Recipients

• Use Section A to identify the agency's department or unit. • Use Section B to identify an individual. • Use Section C to identify an outside organization.

A. Name of Agency, Department or Unit	Number of Ticket(s)/ Passes	Describe the public purpose made pursuant to the agency's policy

B. Name of Individual *(Last, First)*	Number of Ticket(s)/ Passes	Identify one of the following:
		Ceremonial Role ☐ Other ☐ Income ☐ *If checking "Ceremonial Role" or "Other" describe below:*
		Ceremonial Role ☐ Other ☐ Income ☐ *If checking "Ceremonial Role" or "Other" describe below:*
		Ceremonial Role ☐ Other ☐ Income ☐ *If checking "Ceremonial Role" or "Other" describe below:*
		Ceremonial Role ☐ Other ☐ Income ☐ *If checking "Ceremonial Role" or "Other" describe below:*

C. Name of Outside Organization (include address and description)	Number of Ticket(s)/ Passes	Describe the public purpose made pursuant to the agency's policy

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

20. Consider Approval of Reimbursement for Necessary Business Expenditures Incurred by Regular Full-Time or Part-Time Employees on Temporary Telework in Response to the Public Health Emergency Arising from the Coronavirus (COVID-19) Pandemic

Contact

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

Recommended Actions

1. Approve reimbursement at a flat rate of $45 per month, commencing April 1, 2020 through June 30, 2020 for necessary business expenditures incurred by regular full-time and part-time employees on temporary telework in response to the public health emergency arising from the COVID-19 pandemic;
2. Authorize the Chief Executive Officer (CEO) to extend the flat reimbursement rate month-to-month thereafter through December 31, 2020 for employees required to remain on temporary telework;
3. Authorize unbudgeted expenditures of up to $114,750 from existing reserves to fund the reimbursement for necessary business expenses of employees on temporary telework for the period of April 1, 2020, through June 30, 2020; and
4. In the event the CEO authorizes the extension of the flat reimbursement rate on a month-to-month basis for all or part of the period of July 1, 2020, through December 31, 2020, authorize unbudgeted expenditures of up to $229,500 from existing reserves to fund the reimbursement of business expenses for employees on temporary telework.

Background

In response to the national emergency resulting from the COVID-19 pandemic and recommendations for social distancing for COVID-19 community mitigation strategies, beginning in late March 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." In order to maintain continuity of essential services and business functions while maintaining the social distancing guidelines and a safe work environment for CalOptima employees, CalOptima initiated a phased-in deployment of voluntary temporary telework for CalOptima staff whose job duties can be performed remotely.

As the circumstances favor the continuation of temporary telework to minimize the number of employees present in CalOptima buildings and to slow the spread of COVID-19 in our community, management believes a delayed and gradual return of employees from temporary telework will be the best option for the safety of CalOptima employees. As the voluntary temporary telework has evolved over the last few months, and temporary telework is becoming less voluntary, management has evaluated CalOptima's obligations under California Labor Code section 2802 to reimburse employees for reasonable expenses in direct consequence of the performance of their obligations.

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Discussion

Temporary telework was not contemplated as part of CalOptima Policy GA. 8044: Telework Program, and approximately 63% of employees are currently on temporary telework, which does not include those employees who were already teleworking as part of CalOptima's Telework Program. As temporary telework has evolved from a voluntary program to one that is not completely voluntary, CalOptima, as an employer, has an obligation to pay for a "reasonable percentage" of necessary business expenses such as internet and cell phone service even if it does not require an employee to incur an extra cost.

While personal cell phone use is discouraged, management recognizes that during these unique circumstances, occasional use of a personal cell phone might be required on an occasional basis. Management also recognizes that internet costs are not generally covered as a business expense and most employees do not use the internet exclusively for CalOptima business. However, to ensure compliance with reimbursement requirements under the Labor Code during these unique circumstances, management is recommending that employees on temporary telework be provided reimbursement for a reasonable percentage of these necessary business expenses.

Staff has determined that a flat reimbursement rate of forty-five dollars ($45) per month is a reasonable estimate of the proportional cost of cell phone, internet and other necessary business expenses. Management is requesting Board approval of the flat reimbursement rate for employees on temporary telework for the months of April through June 2020, and to permit the reimbursement to continue from month-to-month through December 31, 2020, for each month an employee is required to remain on temporary telework. Employees who believe they are entitled to additional reimbursement must submit an expense reimbursement request with supporting documentation showing why they believe they should receive additional reimbursement, which will be reviewed on a case-by-case basis.

Fiscal Impact

The recommended action to authorize expenditures to fund the monthly reimbursement for necessary business expenses of employees on temporary telework for the period of April 1, 2020, through June 30, 2020, is an unbudgeted item. It is estimated that there are on average 850 regular full-time and part time employees on temporary telework. A proposed allocation of up to $114,750 from existing reserves will fund this action.

Funding for the extension of the flat reimbursement rate on a month-to-month basis was not included in the Fiscal Year 2020-21 Operating Budget pending Board approval. In the event the CEO extends the monthly flat reimbursement rate for all or part of the period of July 1, 2020, through December 31, 2020, a proposed allocation of up to $229,500 from existing reserves will fund this action.

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Rationale for Recommendation

Implementing a flat reimbursement rate will ensure compliance with Labor Code section 2802 to provide reimbursement for necessary business expenses as a result of temporary telework and also avoid the administrative burden of evaluating individual requests and potentially making disparate determinations on the appropriate reimbursement amount based on a reasonable percentage for each expense.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Richard Sanchez *05/27/2020*

Authorized Signature **Date**

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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
21. Consider Authorizing Extension of State Legislative Advocacy Services Contract

Contact
Silver Ho, Executive Director, Compliance, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to exercise the option to extend the contract of Edelstein Gilbert Robson & Smith for state legislative advocacy services for one year, per the terms of the current contract, commencing July 1, 2020.

Background
CalOptima has historically retained representation in Sacramento to assist with tracking and advocacy on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in March 2018 and proposals were received from two advocacy firms. Subsequently, evaluation and interviews were conducted by CalOptima staff, external subject matter experts and a Board ad hoc committee, which recommended Edelstein Gilbert Robson & Smith. On June 7, 2018, the Board authorized the Chief Executive Officer to contract with Edelstein Gilbert Robson & Smith for a one-year term with four one-year options, each exercisable at CalOptima's sole discretion and commencing on July 1, 2018. On June 6, 2019, the Board exercised the first one-year option. Edelstein Gilbert Robson & Smith's current contract term ends on June 30, 2020.

Discussion
Edelstein Gilbert Robson & Smith has substantial knowledge and experience in health care issues important to CalOptima. In the past year, they have engaged with issues including, but not limited to, Proposition 56 implementation, the CalOptima Program of All-Inclusive Care for the Elderly (PACE), the Denti-Cal program, and COVID-19 legislation and State response.

As proposed, the recommended action is to extend Edelstein Gilbert Robson & Smith's contract for an additional one-year term, per the option exercisable at CalOptima's discretion under the current contract. Edelstein Gilbert Robson & Smith's contract fee is $100,000 annually, or $8,333.33 per month. The fee includes phone, fax, in-office copying, regular postage, and printing. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.

Consistent with CalOptima's practice, staff will monitor the performance of Edelstein Gilbert Robson & Smith to ensure that the deliverables and components outlined in the contract are being achieved. Deliverables include, but are not limited to, written and verbal monthly reports, updates and discussions

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with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

Fiscal Impact
Funding for the recommended action to extend the contract from July 1, 2020, through June 30, 2021, with Edelstein Gilbert Robson & Smith for state legislative advocacy services is included in the proposed CalOptima Fiscal Year 2020–21 Operating Budget pending Board approval.

Rationale for Recommendation
State legislative advocacy efforts continue to be a priority for CalOptima given the level of activity on health care issues in Sacramento and Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated June 7, 2018, Consider Authorizing Selection and Contracting for State Legislative Advocacy Services
2. Board Action dated June 6, 2019, Consider Authorizing Extension of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith

/s/ Richard Sanchez *05/27/2020*
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
40. Consider Authorizing Selection and Contracting for State Legislative Advocacy Services

Contact
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Select Edelstein Gilbert Robson & Smith as the recommended state legislative advocacy firm to represent CalOptima for state advocacy services; and
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a contract with the recommended firm, commencing July 1, 2018, for one (1) year, with four (4) one-year extension options, with each extension option exercisable at CalOptima's sole discretion.

Background
CalOptima has historically retained representation in Sacramento to assist with tracking and advocating on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in March 2018 and two proposals were received. An evaluation committee of CalOptima staff and external subject matter experts reviewed and scored the submitted proposals. Subsequently, the two firms were interviewed by Board Members Ron Diluigi and Dr. Nikan Khatibi as members of the State Lobbyist RFP Ad Hoc committee on May 16, 2018.

Discussion
After reviewing the written proposal scores and participating in interviews with both firms, in which a weighted formula was used at 25 percent for the written evaluation and 75 percent for the interview evaluation, the State Lobbyist RFP Ad Hoc committee is recommending Edelstein Gilbert Robson & Smith as CalOptima's state legislative advocacy firm, due to the firm's substantial knowledge of health care issues important to CalOptima. These issues include, but are not limited to, the transition of the California Children's Services program, the County Organized Health System (COHS) model, Prop. 56 implementation, the Cal MediConnect Medicare-Medicaid Plan (CalOptima's OneCare Connect), the Denti-Cal program, Medi-Cal funding and rate issues as well as the potential impact of any changes to the Affordable Care Act.

As proposed, the recommended action is to contract with Edelstein Gilbert Robson & Smith for a one-year term with four one-year options, each exercisable at CalOptima's sole discretion. As proposed by Edelstein Gilbert Robson & Smith, the contract fee would $100,000 annually, or $8,333.33 per month. The fee includes phone, fax, in-office copying, regular postage, and the cost of legislative bills. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.

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Consistent with CalOptima's practice, staff will monitor the performance of Edelstein Gilbert Robson & Smith to ensure that the deliverables and components outlined in the RFP as well as within the contract are being achieved. Deliverables include but are not limited to written and verbal monthly reports, updates and discussions with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

Fiscal Impact
Funding for the recommended actions to contract with the selected firm for state legislative advocacy services is a budgeted item under the proposed CalOptima Fiscal Year 2018–19 Operating Budget pending Board approval.

Rationale for Recommendation
State legislative advocacy efforts continue to be a priority for CalOptima given level of activity on health care in Sacramento and Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. State Legislative Advocacy Services RFP 18-039 – Interview Evaluation Summary
2. State Legislative Advocacy Services RFP 18-039 – Firm Proposal Evaluation Summary

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

5/30/2018 — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
34. Consider Authorizing Extension of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith

Contact
Silver Ho, Executive Director, Compliance, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to exercise an option to extend the contract of Edelstein Gilbert Robson & Smith for state legislative advocacy services for one year, per the terms of the current contract, commencing July 1, 2019.

Background
CalOptima has historically retained representation in Sacramento to assist with tracking and advocacy on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in March 2018 and proposals were received from two advocacy firms. Subsequently, evaluation and interviews were conducted by CalOptima staff, external subject matter experts and a Board ad hoc committee, which recommended Edelstein Gilbert Robson & Smith. On June 7, 2018, the Board authorized a contract with Edelstein Gilbert Robson & Smith for a one-year term with four one-year extension options, each exercisable at CalOptima's sole discretion and commencing on July 1, 2018. Edelstein Gilbert Robson & Smith's current contract term ends on June 30, 2019.

Discussion
Edelstein Gilbert Robson & Smith has substantial knowledge and experience in health care issues important to CalOptima. In the past year, they have engaged with issues including, but not limited to, budget legislation impacting the transition of the California Children's Services program, Proposition 56 implementation, the OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), the Denti-Cal program, and Medi-Cal funding and rate issues.

As proposed, the recommended action is to extend Edelstein Gilbert Robson & Smith's contract for an additional one-year term, by exercising the first of the four one-year extension options under the current contract. Edelstein Gilbert Robson & Smith's contract fee is $100,000 annually, or $8,333.33 per month. The fee includes phone, fax, in-office copying, regular postage, and printing. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.

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Consistent with CalOptima's practice, staff will continue to monitor the performance of Edelstein Gilbert Robson & Smith to ensure that the deliverables and components outlined in the contract are being achieved. Deliverables include, but are not limited to, written and verbal monthly reports, updates and discussions with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

Fiscal Impact

Funding for the recommended action to extend the contract from July 1, 2019, through June 30, 2020, with Edelstein Gilbert Robson & Smith for state legislative advocacy services is a budgeted item under the proposed CalOptima Fiscal Year 2019–20 Operating Budget pending Board approval.

Rationale for Recommendation

State legislative advocacy efforts continue to be a priority for CalOptima given the level of activity on health care issues in Sacramento and Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Board Action dated June 7, 2018, Consider Authorizing Selection and Contracting for State Legislative Advocacy Services

/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
40. Consider Authorizing Selection and Contracting for State Legislative Advocacy Services

Contact
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Select Edelstein Gilbert Robson & Smith as the recommended state legislative advocacy firm to represent CalOptima for state advocacy services; and
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a contract with the recommended firm, commencing July 1, 2018, for one (1) year, with four (4) one-year extension options, with each extension option exercisable at CalOptima's sole discretion.

Background
CalOptima has historically retained representation in Sacramento to assist with tracking and advocating on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in March 2018 and two proposals were received. An evaluation committee of CalOptima staff and external subject matter experts reviewed and scored the submitted proposals. Subsequently, the two firms were interviewed by Board Members Ron Diluigi and Dr. Nikan Khatibi as members of the State Lobbyist RFP Ad Hoc committee on May 16, 2018.

Discussion
After reviewing the written proposal scores and participating in interviews with both firms, in which a weighted formula was used at 25 percent for the written evaluation and 75 percent for the interview evaluation, the State Lobbyist RFP Ad Hoc committee is recommending Edelstein Gilbert Robson & Smith as CalOptima's state legislative advocacy firm, due to the firm's substantial knowledge of health care issues important to CalOptima. These issues include, but are not limited to, the transition of the California Children's Services program, the County Organized Health System (COHS) model, Prop. 56 implementation, the Cal MediConnect Medicare-Medicaid Plan (CalOptima's OneCare Connect), the Denti-Cal program, Medi-Cal funding and rate issues as well as the potential impact of any changes to the Affordable Care Act.

As proposed, the recommended action is to contract with Edelstein Gilbert Robson & Smith for a one-year term with four one-year options, each exercisable at CalOptima's sole discretion. As proposed by Edelstein Gilbert Robson & Smith, the contract fee would $100,000 annually, or $8,333.33 per month. The fee includes phone, fax, in-office copying, regular postage, and the cost of legislative bills. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.

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Consistent with CalOptima's practice, staff will monitor the performance of Edelstein Gilbert Robson & Smith to ensure that the deliverables and components outlined in the RFP as well as within the contract are being achieved. Deliverables include but are not limited to written and verbal monthly reports, updates and discussions with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

Fiscal Impact
Funding for the recommended actions to contract with the selected firm for state legislative advocacy services is a budgeted item under the proposed CalOptima Fiscal Year 2018–19 Operating Budget pending Board approval.

Rationale for Recommendation
State legislative advocacy efforts continue to be a priority for CalOptima given level of activity on health care in Sacramento and Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. State Legislative Advocacy Services RFP 18-039 – Interview Evaluation Summary
2. State Legislative Advocacy Services RFP 18-039 – Firm Proposal Evaluation Summary

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

5/30/2018 — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

22. Consider Authorizing Amendments to the CalOptima Direct Medi-Cal Primary Care Physician, Specialist Physician, and Clinic Fee-for-Service Contracts, Except Those Involving Providers Affiliated with St. Joseph Health

Contact

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

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Direct Medi-Cal Primary Care Physician, Specialist Physician, and Clinic Fee-for-Service (FFS) Contracts Except Those Involving Providers Affiliated with St. Joseph Health, to add language allowing applicable Directed Payments to be made per CalOptima Policy and Procedure FF.2012.

Background/ Discussion

CalOptima is required periodically by the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) guidance to make statutorily mandated payments to CalOptima Direct Medi-Cal FFS providers. These payments, which are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF), are add-on payments or minimum rates associated with qualifying codes, provider eligibility criteria, and specified dates of service as prescribed by applicable DHCS All Plan Letters or other regulatory guidance. In many cases, these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years, and often based on actual claims paid. Until now, CalOptima has been administering Proposition 56 payments to its FFS physicians via contract amendment, as notification comes down from the state or federal government. Given the ongoing nature of these payments, multiple amendments, retroactive contract terms, and timeliness of payment to the impacted providers have been of ongoing concern.

Subject to Board approval of Consent Item #6 on the June 4, 2020 CalOptima Board of Directors' meeting agenda, ("*Consider Approval of CalOptima Medi-Cal Directed Payments Policy, Modifications to Claims Administrations Policies and Procedures*"), in which staff has recommended an alternative approach that mitigates the concerns associated with repeated contract amendments for Directed Payments. The policy considered by the Board in Consent Item #6 (FF.2012) defines Directed Payments and other supplemental payments, and provides procedural guidelines for administering them pursuant to qualifying services being rendered to CalOptima Direct or CCN members. As such, staff recommends amending the CalOptima Direct Medi-Cal Primary Care Physician, Specialist Physician and Clinic Fee-for-Service Contracts, except those involving providers affiliated with St. Joseph Health, to reflect language allowing applicable Directed Payments to be made according to Policy FF. 2012, which addresses the Proposition 56 Directed Payment Programs listed below:

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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

As an alternative to requesting authority to amend contracts for Directed Payments on each individual occasion, staff recommends that, on a go forward basis, Directed Payments be administered according to Policy FF.2012. Staff anticipates that Policy FF.2012 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS or if existing Directed Payment programs are eliminated by DHCS.

Fiscal Impact

The recommended action to amend the CalOptima Direct Medi-Cal Primary Care Physician, Specialist Physician and Clinic FFS Contracts, except those involving Providers affiliated with St. Joseph Health, to add language to make Directed Payments in accordance with CalOptima Policy 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 associated with Directed Payments, staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation

Amending CalOptima Direct Medi-Cal Primary Care Physician, Specialist Physician, and Clinic Fee-for-Service (FFS) Contracts except those involving providers affiliated with St. Joseph Health, will streamline the process of administering Directed Payments and other supplemental payments and minimize concerns associated with the need for individual amendments on a case by case basis.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Policy & Procedure FF.2012; Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shard Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

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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

For 20200604 BOD Review Only

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima shall administer Directed Payments for Qualifying Services rendered to CalOptima Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima claims and utilization management policies, including but not limited to CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Direct or a Shared Risk Group on the date of service.

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

For 20201604 BOD Review Only

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.

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f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. 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.

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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.

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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

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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

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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				

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IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
CalOptima Direct	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.

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Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program 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.

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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.

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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.

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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

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[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

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	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

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **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*

For 20200604 BOD Review Only

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 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
23. Consider Authorizing Amendments to the CalOptima Direct Medi-Cal Non-Clinic Primary Care Physician Fee-for-Service Contracts for Providers Affiliated with St. Joseph Health

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

Recommended Actions
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Direct Medi-Cal Non-Clinic Primary Care Physician Fee-for-Service (FFS) Contracts for Providers Affiliated with St. Joseph Health, to add language allowing applicable Directed Payments to be made per CalOptima Policy and Procedure FF.2012.

Background/ Discussion
CalOptima is required periodically by the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) guidance to make statutorily mandated payments to CalOptima Direct Medi-Cal FFS providers. These payments, which are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF), are add-on payments or minimum rates associated with qualifying codes, provider eligibility criteria, and specified dates of service as prescribed by applicable DHCS All Plan Letters or other regulatory guidance. In many cases, these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years, and often based on actual claims paid. Until now, CalOptima has been administering Proposition 56 payments to its FFS physicians via contract amendment, as notification comes down from the state or federal government. Given the ongoing nature of these payments multiple amendments, retroactive contract terms, and timeliness of payment to the impacted providers have been of ongoing concern.

Subject to Board approval of Consent Item #6 on the June 4, 2020 CalOptima Board of Directors' meeting agenda, ("*Consider Approval of CalOptima Medi-Cal Directed Payments Policy, Modifications to Claims Administrations Policies and Procedures*"), in which staff has recommended an alternative approach that mitigates the concerns associated with repeated contract amendments for Directed Payments. The policy considered by the Board in Consent Item #6 (FF.2012) defines Directed Payments and other supplemental payments, and provides procedural guidelines for administering them pursuant to qualifying services being rendered to CalOptima Direct or CCN members. As such, staff recommends amending the CalOptima Direct Medi-Cal Non-Clinic Primary Care Physician Fee-for-Service Contracts for Providers Affiliated with St. Joseph Health to reflect language allowing applicable Directed Payments to be made according to Policy FF. 2012, which addresses the Proposition 56 Directed Payment Programs listed below:

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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

As an alternative to requesting authority to amend contracts for Directed Payments on each individual occasion, staff recommends that, on a go forward basis, Directed Payments be administered according to Policy FF.2012. Staff anticipates that Policy FF.2012 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS or if existing Directed Payment programs are eliminated by DHCS.

Fiscal Impact

The recommended action to amend the CalOptima Direct Medi-Cal Non-Clinic Primary Care Physician FFS Contracts for Providers affiliated with St. Joseph Health to add language to make Directed Payments in accordance with CalOptima Policy 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 associated with Directed Payments, staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation

Amending CalOptima Direct Medi-Cal Non-Clinic Primary Care Physician Fee-for-Service Contracts for Providers Affiliated with St. Joseph Health will streamline the process of administering Directed Payments and other supplemental payments and minimize concerns associated with the need for individual amendments on a case by case basis.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Policy & Procedure FF.2012; Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shard Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

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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

For 20200604 BOD Review Only

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima shall administer Directed Payments for Qualifying Services rendered to CalOptima Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima claims and utilization management policies, including but not limited to CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Direct or a Shared Risk Group on the date of service.

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

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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.

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f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. 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.

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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.

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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

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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

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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				

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IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
CalOptima Direct	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.

For 20200604 BOD Review Only

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program 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.

For 2020060A BOD Review Only

Term	Definition
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Eligible Contracted Provider	An individual rendering Provider who is contracted with CalOptima to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to CalOptima Direct and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with CalOptima does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
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.

For 2020060 BOD Review Only

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.

For 2020604 BOD Review Only

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[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

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	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

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **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*

For 20200604 BOD Review Only

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 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
24. Consider Authorizing Amendments to the CalOptima Direct Medi-Cal Clinic Fee-for-Service Contracts Affiliated with St. Joseph Health

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

Recommended Actions
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Direct Medi-Cal Clinic Fee-for-Service (FFS) Contracts with Clinics affiliated with St. Joseph Health, to add language allowing applicable Directed Payments to be made per CalOptima Policy and Procedure FF.2012.

Background/ Discussion
CalOptima is required periodically by the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) guidance to make statutorily mandated payments to CalOptima Direct Medi-Cal FFS providers. These payments, which are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF), are add-on payments or minimum rates associated with qualifying codes, provider eligibility criteria, and specified dates of service as prescribed by applicable DHCS All Plan Letters or other regulatory guidance. In many cases, these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years, and often based on actual claims paid. Until now, CalOptima has been administering Proposition 56 payments to its FFS physicians via contract amendment, as notification comes down from the state or federal government. Given the ongoing nature of these payments multiple amendments, retroactive contract terms, and timeliness of payment to the impacted providers have been of ongoing concern.

Subject to Board approval of Consent Item #6 on the June 4, 2020 CalOptima Board of Directors' meeting agenda, ("*Consider Approval of CalOptima Medi-Cal Directed Payments Policy, Modifications to Claims Administrations Policies and Procedures*"), in which staff has recommended an alternative approach that mitigates the concerns associated with repeated contract amendments for Directed Payments. The policy considered by the Board in Consent Item #6 (FF.2012) defines Directed Payments and other supplemental payments and provides procedural guidelines for administering them pursuant to qualifying services being rendered to CalOptima Direct or CCN members. As such, staff recommends amending the CalOptima Direct Medi-Cal Clinic Fee-for-Service Contracts with clinics affiliated with St. Joseph Health, to reflect language allowing applicable Directed Payments to be made according to Policy FF. 2012, which addresses the Proposition 56 Directed Payment Programs listed below:

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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

As an alternative to requesting authority to amend contracts for Directed Payments on each individual occasion, staff recommends that, on a go forward basis, Directed Payments be administered according to Policy FF.2012. Staff anticipates that Policy FF.2012 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS or if existing Directed Payment programs are eliminated by DHCS.

Fiscal Impact
The recommended action to amend the CalOptima Direct Medi-Cal clinic FFS contracts with clinics affiliated with St. Joseph Health to add language to make Directed Payments in accordance with CalOptima Policy 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 associated with Directed Payments, staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation
Amending CalOptima Direct Medi-Cal Clinic Fee-for-Service (FFS) Contracts with clinics affiliated with St. Joseph Health will streamline the process of administering Directed Payments and other supplemental payments and minimize concerns associated with the need for individual amendments on a case by case basis.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. Policy & Procedure FF.2012; Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shard Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

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

For 20200604 BOD Review Only

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima shall administer Directed Payments for Qualifying Services rendered to CalOptima Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima claims and utilization management policies, including but not limited to CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Direct or a Shared Risk Group on the date of service.

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

For 20201604 BOD Review Only

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.

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f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. 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.

For 20200604 BOD Review Only

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.

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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

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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

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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				

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IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
CalOptima Direct	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.

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Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program 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.

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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.

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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.

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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

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[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

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	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

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **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*

For 20200604 BOD Review Only

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 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
25. Consider Authorizing Amendments to the CalOptima Direct Medi-Cal Specialist Physician Fee-for-Service Contracts for Providers Affiliated with St. Joseph Health

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Direct Medi-Cal Specialist Physician Fee-for-Service (FFS) Contracts for Providers Affiliated with St. Joseph Health to add language allowing applicable Directed Payments to be made per CalOptima Policy and Procedure FF.2012.

Background/ Discussion
CalOptima is required periodically by the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) guidance to make statutorily mandated payments to CalOptima Direct Medi-Cal FFS providers. These payments, which are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF), are add-on payments or minimum rates associated with qualifying codes, provider eligibility criteria, and specified dates of service as prescribed by applicable DHCS All Plan Letters or other regulatory guidance. In many cases, these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years, and often based on actual claims paid. Until now, CalOptima has been administering Proposition 56 payments to its FFS physicians via contract amendment, as notification comes down from the state or federal government. Given the ongoing nature of these payments, multiple amendments, retroactive contract terms, and timeliness of payment to the impacted providers have been of ongoing concern.

Subject to approval of Consent Item #6 on the June 4, 2020 CalOptima Board of Directors' meeting agenda, ("*Consider Approval of CalOptima Medi-Cal Directed Payments Policy, Modifications to Claims Administrations Policies and Procedures*"), in which staff has recommended an alternative approach that mitigates the concerns associated with repeated contract amendments for Directed Payments. The policy considered by the Board in Consent Item #6 (FF.2012) defines Directed Payments and other supplemental payments and provides procedural guidelines for administering them pursuant to qualifying services being rendered to CalOptima Direct or CCN members. As such, staff recommends amending the CalOptima Direct Medi-Cal Specialist Physician Fee-for-Service Contracts for Providers Affiliated with St. Joseph Health, to reflect language allowing applicable Directed Payments to be made according to Policy FF. 2012, which addresses the Proposition 56 Directed Payment Programs listed below:

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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

As an alternative to requesting authority to amend contracts for Directed Payments on each individual occasion, staff recommends that, on a go forward basis, Directed Payments be administered according to Policy FF.2012. Staff anticipates that Policy FF.2012 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS or if existing Directed Payment programs are eliminated by DHCS.

Fiscal Impact

The recommended action to amend the CalOptima Direct Medi-Cal Specialist Physician FFS Contracts for Providers affiliated with St. Joseph Health to add language to make Directed Payments in accordance with CalOptima Policy 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 associated with Directed Payments, staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation

Amending CalOptima Direct Medi-Cal Specialist Physician Fee-for-Service (FFS) Contracts for Providers affiliated with St. Joseph Health will streamline the process of administering Directed Payments and other supplemental payments and minimize concerns associated with the need for individual amendments on a case by case basis.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Policy & Procedure FF.2012; Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shard Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services

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

05/27/2020 — **Date**

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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

For 20200604 BOD Review Only

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima shall administer Directed Payments for Qualifying Services rendered to CalOptima Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima claims and utilization management policies, including but not limited to CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Direct or a Shared Risk Group on the date of service.

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

For 20201604 BOD Review Only

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.

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f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. 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.

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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.

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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

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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

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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				

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IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
CalOptima Direct	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.

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Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program 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.

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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.

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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.

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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

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[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

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	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

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **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*

For 20200604 BOD Review Only

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 4, 2020
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Actions
Adopt Resolution approving updates to the following CalOptima Human Resources Policies:
1. GA.8055: Retiree Health Benefits;
2. GA.8025: Equal Employment Opportunity;
3. AA.1250: Disability Awareness and Sensitivity, and Cultural Competency Staff Training;
4. CMC.1003: CalOptima OneCare Connect Staff Education and Training; and
5. GA.8057: Compensation Program

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 has been updated and are being presented for Board of Directors' review and approval.

Policy No./Name	Summary of Changes	Reason for Change
GA.8055: Retiree Health Benefits	• Addition of requirement to provide proof of Medicare coverage, once eligible • Minor revisions and verbiage clarification.	• This is an existing policy that provides detailed guidelines on how to administer retiree health benefits for those who qualify. • Annual review of the policy. • Revised content to reflect current practices.
GA.8025: Equal Employment Opportunity	• Update language consistent with Senate Bill 1300 revising Government Code section 12940. • Minor revisions and verbiage clarification.	• This policy outlines CalOptima's approach to Equal Employment Opportunity. • SB 1300 added additional protected categories and requirements. • Annual review of the policy. • Revised content for clarity.

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Policy No./Name	Summary of Changes	Reason for Change
AA.1250: Disability Awareness and Sensitivity, and Cultural Competency Staff Training •	• Minor revision – added statement regarding retention of training records and added topic of HIV/AIDS to training requirements.	• This policy outlines the initial and ongoing Training and Education requirements for CalOptima Employees to ensure they are knowledgeable about the standards for disability competency, cultural awareness, and sensitivity for all CalOptima Members. • Added at the request of Compliance.
CMC.1003: CalOptima OneCare Connect Staff Education and Training	• Minor revision – added statement regarding retention of training records.	• Added at the request of Compliance.
GA.8057: Compensation Program Attachment A – Compensation Guidelines	• Deleted language to comply with the California Equal Pay Act requirements. • Minor language and formatting changes to the Policy. • Attachment A – Compensation Guidelines updated with: o Minor language and formatting changes; o Revised merit pay calculation methodology to coincide with fiscal year; o Provide clarifying language and modifications to reflect current operational processes and practices; o Clarify the method for calculating salary for promotions, demotions and transfers; o Included language allowing for a replacement to fill a budgeted position in advance of a terminating employee's separation; o The proposed implementation date of the Compensation Guidelines is March 29, 2020.	• Revised Policy to comply with California Equal Pay Act, Labor Code section 1197.5 and Labor Code section 432.3 • Clarifying language provided for ease of comprehension and consistent application and to reflect current compensation practices • The March 29, 2020, implementation of the Compensation Guidelines is to account for the beginning of the pay period when there was an overlap with the interim and separating chief executive officer to allow for a transition/training period

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Fiscal Impact
The recommended action to revise existing CalOptima Human Resources 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 pending Board approval.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 20-0604-02, Approve Updated Human Resources Policies
2. Revised CalOptima Policies:
    a. GA.8055: Retiree Health Benefits (redlined and clean copy)
    b. GA.8025: Equal Employment Opportunities (redlined and clean copy)
    c. AA.1250: Disability Awareness and Sensitivity, and Cultural Competency Staff Training (redlined and clean copy)
    d. CMC.1003: CalOptima OneCare Connect Staff Education and Training (redlined and clean copy)
    e. GA.8057: Compensation Program with revised Attachment A (redlined and clean copy)

/s/ Richard Sanchez *05/27/2020*
Authorized Signature Date

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RESOLUTION NO. 20-0604-02

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:

a. GA.8055: Retiree Health Benefits
b. GA.8025: Equal Employment Opportunities
c. AA.1250: Disability Awareness and Sensitivity, and Cultural Competency Staff Training,
d. CMC.1003: CalOptima OneCare Connect Staff Education and Training
e. GA.8057: Compensation Program

Section 2. That the Chief Executive Officer is authorized to implement the revised Compensation Guidelines with an implementation date of March 29, 2020.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this June 4, 2020.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

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

Policy ~~#:~~:	GA.8055
Title:	**Retiree Health Benefit**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	~~Michael Schrader~~
Effective Date:	05/01/~~14~~2014
Revised Date:	06/04/2020

~~*Board Approved Policy*~~

I. PURPOSE

This policy provides detailed guidelines on how to administer retiree health benefits for ~~CalOptima's Current Retirees and Eligible Employees~~those who qualify for retiree health benefits under this policy.

II. POLICY

A. Retiree health benefits are available to ~~Current Retiree~~Current Retirees ~~and Eligible Employee~~Eligible Employees. Retiree health benefits are not available to employees who: (1) were initially hired on or after January 1, 2004, or (2) employees who were ~~originally~~ hired ~~before January 1, 2004, separated from employment and was~~or rehired on or after December 1, 2013.

B. ~~Eligible Retiree~~Eligible Retirees and, if elected and paid for by the ~~Eligible Retiree~~Eligible Retirees, the ~~Eligible Dependent~~Eligible Dependents of ~~Current Retiree~~Current Retirees, ~~Retired Eligible Employee~~Retired Eligible Employees, or ~~Reinstated Eligible Retiree~~Reinstated Eligible Retirees, will, until the CalOptima Board of Directors ("Board") decides that CalOptima will no longer continue the program or otherwise modifies it, be eligible to receive retiree health benefits as follows:

1. *Not Medicare Eligible*: If the ~~Eligible Retiree~~Eligible Retiree and/or the ~~Eligible Dependent~~Eligible Dependent(s) is/are not yet eligible for Medicare, then the ~~Eligible Retiree~~Eligible Retiree and/or the ~~Eligible Dependent~~Eligible Dependent(s) will receive the same health insurance coverage as active employees and their dependents subject to the limitations below. The ~~Eligible Retiree~~Eligible Retiree's share of premiums for the ~~Eligible Retiree~~Eligible Retiree's health insurance coverage will be the same as those paid by active employees for similar coverage. In the event CalOptima is unable to reasonably obtain health insurance coverage for the ~~Eligible Dependent~~Eligible Dependent(s) who are not Medicare eligible, CalOptima may provide a stipend to the ~~Eligible Dependent~~Eligible Dependent(s) in lieu of health insurance coverage in an amount calculated based on the proportional amount CalOptima pays for the most closely analogous active employee health insurance coverage for active employees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima would have paid for the most closely analogous health insurance coverage for the ~~Eligible Dependent~~Eligible Dependent(s). Proof of coverage, along with evidence of payments for health care coverage, must be submitted to CalOptima in order for the stipend to be paid.

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2. *Medicare Eligible*: If the ~~Eligible Retiree~~Eligible Retiree and/or the ~~Eligible Dependent~~Eligible Dependent(s) is/are Medicare eligible, then the ~~Eligible Retiree~~Eligible Retiree and/or the ~~Eligible Dependent~~Eligible Dependent(s) will be required to enroll, at the ~~Eligible Retiree~~Eligible Retiree's expense, in Medicare Part A and/or Part B, as a condition of receiving retiree health benefits under this policy. Proof of Medicare coverage must be submitted to Human Resources. The ~~Eligible Retiree~~Eligible Retiree may select one (1) of the Medicare supplemental coverage options offered by CalOptima for the Medicare ~~Eligible Retiree~~Eligible Retiree and/or the ~~Eligible Dependent~~Eligible Dependent(s). The ~~Eligible Retiree~~Eligible Retiree's share of the Medicare supplemental coverage premium will be calculated based on the same proportional amount active employees pay for the most closely analogous active employee health insurance coverage for the active employee and their dependents. In the event CalOptima is unable to reasonably obtain Medicare Supplemental coverage for the ~~Eligible Dependent~~Eligible Dependent(s) who are Medicare eligible, CalOptima may provide a stipend to the ~~Eligible Dependent~~Eligible Dependent(s) in lieu of Medicare Supplemental coverage in an amount calculated based on the proportional amount CalOptima pays for the most closely analogous Medicare supplemental coverage for ~~Eligible Retiree~~Eligible Retirees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima would have paid for the most closely analogous Medicare Supplemental coverage for the ~~Eligible Dependent~~Eligible Dependent(s). Proof of coverage, along with evidence of payments for Medicare Supplemental coverage, must be submitted to CalOptima in order for the stipend to be paid.

C. This retiree health benefit policy is completely voluntary on the part of CalOptima and may be amended, or terminated, by the CalOptima Board at any time in its sole discretion. This policy shall not create any vested benefits for any person, or categories of persons.

D. The Chief Executive Officer of CalOptima is charged with administering and interpreting this policy. When addressing any issue that is not dealt with in the Policy, the Chief Executive Officer shall consider and give weight to what the result would have been if CalOptima were still providing its employee health insurance through CalPERS.

E. This policy shall supersede any and all prior Board actions or policies concerning retiree health benefits.

III. PROCEDURE

A. The following provisions set forth the enrollment requirements for an ~~Eligible Retiree~~Eligible Retiree to receive Retiree Health Benefits:

1. A ~~Retired Eligible Employee~~Retired Eligible Employee must enroll him/herself and his/her ~~Eligible Dependent~~Eligible Dependents within sixty (60) calendar days of the ~~Retired Eligible Employee~~Retired Eligible Employee's ~~Retirement Date~~Retirement Date~~,~~ or must wait to enroll during the annual open enrollment period applicable to active employees.

2. An ~~Eligible Retiree~~Eligible Retiree must elect the Medicare coverage option he or she wants within sixty (60) calendar days of the ~~Eligible Retiree~~Eligible Retiree and/or the ~~Eligible Dependent~~Eligible Dependent becoming Medicare eligible and provide proof of Medicare coverage to Human Resources.

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3. A Reinstated ~~Eligible Employee~~Eligible Employee must enroll within sixty (60) calendar days of his or her ~~Subsequent Retirement Date~~Subsequent Retirement Date.

4. A ~~Survivor Dependent~~Survivor Dependent may continue coverage without interruption or enroll for ~~Survivor Dependent~~Survivor Dependent coverage by submitting all necessary documentation within sixty (60) calendar days of the death of the ~~Eligible Retiree~~Eligible Retiree.

5. Health insurance coverage options may be changed by an ~~Eligible Retiree~~Eligible Retiree during the annual open enrollment period and for defined qualifying events applicable for active employees who are covered under CalOptima's employee health plan

B. Retiree health benefits coverage will begin upon one (1) of the following:

1. If an ~~Eligible Employee~~Eligible Employee enrolls within sixty (60) calendar days of separation from CalOptima and his or her ~~Retirement Date~~Retirement Date, then the retiree health benefits coverage for the ~~Retired Eligible Employee~~Retired Eligible Employee and the ~~Eligible Dependent~~Eligible Dependent(s) will begin on the first day of the month following the date CalOptima timely receives the completed health enrollment forms from the ~~Eligible Employee~~Eligible Employee.

2. If the ~~Retired Eligible Employee~~Retired Eligible Employee fails to enroll within sixty (60) calendar days of his or her ~~Retirement Date~~Retirement Date, but subsequently enrolls during any future open enrollment period applicable for active employees, retiree health benefits coverage will begin on the following January 1.

3. Retiree health benefits coverage for an Eligible ~~Survivor Dependent~~Survivor Dependent will continue uninterrupted upon submission of all required documentation or begin on the first day of the month following timely enrollment for coverage as a ~~Survivor Dependent~~Survivor Dependent.

4. If a Reinstated ~~Eligible Employee~~Eligible Employee timely enrolls within sixty (60) calendar days of his or her ~~Subsequent Retirement Date~~Subsequent Retirement Date, then the retiree health benefits coverage for the Reinstated ~~Eligible Employee~~Eligible Employee and the ~~Eligible Dependent~~Eligible Dependent(s) will begin on the first day of the month following the date CalOptima timely receives the completed health enrollment forms from the Reinstated ~~Eligible Employee~~Eligible Employee.

C. If an ~~Eligible Employee~~Eligible Employee separates from CalOptima before CalOptima receives notice from CalPERS that the ~~Eligible Employee~~Eligible Employee has/will become an annuitant, the ~~Eligible Employee~~Eligible Employee will be offered termination of health coverage information and a COBRA health plan continuation packet. After CalOptima receives notice from CALPERS of the ~~Eligible Employee~~Eligible Employee's retirement effective date, CalOptima will forward a packet to the ~~Retired Eligible Employee~~Retired Eligible Employee concerning retiree health benefits. The ~~Retired Eligible Employee~~Retired Eligible Employee must enroll him/herself and his/her ~~Eligible Dependent~~Eligible Dependents within sixty (60) calendar days of the ~~Retired Eligible Employee~~Retired Eligible Employee's ~~Retirement Date~~Retirement Date or must wait to enroll during the next annual open enrollment period applicable to active employees. (NOTE: If the retirement effective date indicated by CalPERS is postdated to the date of separation or other earlier date, and CalOptima does not receive notice from CalPERS until more than sixty (60)

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calendar days after such date, the ~~Retired Eligible Employee~~Retired Eligible Employee must wait to enroll during the next annual open enrollment period.). If the ~~Retired Eligible Employee~~Retired Eligible Employee needs access to health coverage before the retiree health benefits coverage will begin, the ~~Retired Eligible Employee~~Retired Eligible Employee will need to elect and pay for COBRA health plan continuation or pay for an alternative health plan until then.

D. Retiree health benefit coverage will terminate upon the following:

1. For ~~Eligible Retiree~~Eligible Retirees, upon death of the ~~Eligible Retiree~~Eligible Retiree.

2. For ~~Eligible Dependent~~Eligible Dependents, upon death of the ~~Eligible Retiree~~Eligible Retiree, unless the ~~Eligible Dependent~~Eligible Dependent is an Eligible ~~Survivor Dependent~~Survivor Dependent~~, or upon the failure of an Eligible Retiree to timely pay any required premiums.~~.

3. For ~~Current Retiree~~Current Retirees and ~~Retired Eligible Employee~~Retired Eligible Employees who are reinstated from retirement:

   a. During the period of reinstatement that ends CalPERS retirement annuity payments; and

   b. During and after the ~~Subsequent Retirement Date~~Subsequent Retirement Date if the ~~Current Retiree~~Current Retiree and/or ~~Retired Eligible Employee~~Retired Eligible Employee subsequently terminates employment from another state employer who provides retiree health benefits with a retiree share premium that is less than, or equal to, that being charged by CalOptima under this policy.

4. Upon the failure of an ~~Eligible Retiree~~Eligible Retiree or Eligible ~~Survivor Dependent~~Survivor Dependent to ~~timely~~ pay any required premiums~~.~~ within ninety (90) calendar days of payment due date.

5. When the CalOptima Board elects to terminate retiree health benefits, in part, or in its entirety.

6. Upon the failure ~~of an Eligible Retiree~~ to ~~timely~~ obtain and certify Medicare coverage within ninety (90) calendar days upon ~~his/her~~ the ~~Eligible Retiree~~Eligible Retiree or the ~~Eligible Dependent~~Eligible Dependent(s) becoming Medicare eligible.

~~IV. ATTACHMENTS~~

7. Upon the failure of an ~~Eligible Retiree~~Eligible Retiree or ~~Eligible Dependent~~Eligible Dependent to maintain the required Medicare coverage.

IV. ATTACHMENT(S)

Not Applicable

~~V. REFERENCES~~

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY ~~APPROVALS~~APPROVAL(S)

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None to Date

VII. BOARD ACTIONSACTION(S)

A. 11/03/16: Regular Meeting of the CalOptima Board of Directors
B. 06/02/16: Regular Meeting of the CalOptima Board of Directors
C. 08/07/14: Regular Meeting of the CalOptima Board of Directors

REVIEW/

VIII.I. REVISION HISTORY

Date	Meeting
Date08/07/2014	Line(s) of BusinessRegular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	08/07/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	06/02/2016	GA.8055	Retiree Health Benefit	Administrative
Revised	11/03/2016	GA.8055	Retiree Health Benefit	Administrative
Revised	11/07/2019	GA.8055	Retiree Health Benefit	Administrative
Revised	06/04/2020	GA.8055	Retiree Health Benefit	Administrative

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IX. GLOSSARY

Term	Definition
~~Current Retiree~~Current Retiree	Former employee of CalOptima who: 1. Was hired before January 1, 2004; 2. Completed at least five (5) years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS); and 3. Was already receiving retiree health benefits from CalOptima on January 1, 2014.
~~Eligible Dependent~~Eligible Dependent	The current spouse, registered domestic partner, dependent child up to age 26, and/or certified disabled dependent child over age 26, of a ~~Current Retiree~~Current Retiree, ~~Retired Eligible Employee~~Retired Eligible Employee, or ~~Reinstated Eligible Retiree~~Reinstated Eligible Retiree, who: 1. Meets the definition of a dependent who is eligible for coverage under the employee health plan then maintained by CalOptima for its active employees; and 2. Has been timely enrolled for coverage under this retiree health policy by the ~~Eligible Retiree~~Eligible Retiree.
~~Eligible Employee~~Eligible Employee	A current active employee of CalOptima meeting the following criteria: 1. The most recent date of hire was before January 1, 2004, or whose initial date of hire was before January 1, 2004, and whose most recent rehire date was before December 1, 2013; 2. Completes at least five (5) years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS).
~~Eligible Retiree~~Eligible Retiree	~~Current Retiree~~Current Retiree, ~~Retired Eligible Employee~~Retired Eligible Employee, ~~Reinstated Eligible Retiree~~Reinstated Eligible Retiree or Eligible ~~Survivor Dependent~~Survivor Dependent.
Eligible ~~Survivor Dependent~~Survivor Dependent	A ~~Survivor Dependent~~Survivor Dependent who timely enrolls for ~~Survivor Dependent~~Survivor Dependent health coverage within sixty (60) calendar days of the death of the ~~Eligible Retiree~~Eligible Retiree.

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Term	Definition
~~Reinstated Eligible Retiree~~Reinstated Eligible Retiree	A ~~Current Retiree~~Current Retiree or ~~Retired Eligible Employee~~Retired Eligible Employee whose CalPERS retirement annuity and benefits under this Policy ended due to a reinstatement from retirement as defined in Government Code §§22838 and 21190 et.seq., or successor sections, and who (i) subsequently terminates employment from another state employer who does not provide retiree health benefits with a retiree share premium that is less than or equal to that being charged by CalOptima under this Policy; (ii) once again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of such subsequent separation from employment; and (iii) timely enrolls for resumption of coverage under this Policy.
~~Retired Eligible Employee~~Retired Eligible Employee	~~Eligible Employee~~Eligible Employee who: 1. Retires within one hundred twenty (120) calendar days of such ~~Eligible Employee~~Eligible Employee's separation from employment with CalOptima and receives a monthly retirement allowance from CalPERS; and 2. Timely applies for retiree health benefits in accordance with this policy on and after January 1, 2014.
~~Retirement Date~~Retirement Date	Date ~~Eligible Employee~~Eligible Employee becomes an annuitant with CalPERS within one hundred twenty (120) calendar days of such ~~Eligible Employee~~Eligible Employee's separation from employment with CalOptima.
~~Subsequent Retirement Date~~Subsequent Retirement Date	Date ~~Reinstated Eligible Retiree~~Reinstated Eligible Retiree again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of separating from employment with the subsequent state employer described in that definition.
~~Survivor Dependent~~Survivor Dependent	~~Eligible Dependent~~Eligible Dependent who: 1. Survives an ~~Eligible Retiree~~Eligible Retiree; and 2. Is collecting monthly survivor benefits from CalPERS that is attributable to a deceased ~~Current Retiree~~Current Retiree, ~~Retired Eligible Employee~~Retired Eligible Employee, or Reinstated ~~Eligible Employee~~Eligible Employee.

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Policy:	GA.8055
Title:	**Retiree Health Benefit**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	_____
Effective Date:	05/01/2014
Revised Date:	06/04/2020

I. PURPOSE

This policy provides detailed guidelines on how to administer retiree health benefits for those who qualify for retiree health benefits under this policy.

II. POLICY

A. Retiree health benefits are available to Current Retirees and Eligible Employees. Retiree health benefits are not available to employees who: (1) were initially hired on or after January 1, 2004, or (2) employees who were hired or rehired on or after December 1, 2013.

B. Eligible Retirees and, if elected and paid for by the Eligible Retirees, the Eligible Dependents of Current Retirees, Retired Eligible Employees, or Reinstated Eligible Retirees, will, until the CalOptima Board of Directors ("Board") decides that CalOptima will no longer continue the program or otherwise modifies it, be eligible to receive retiree health benefits as follows:

1. *Not Medicare Eligible*: If the Eligible Retiree and/or the Eligible Dependent(s) is/are not yet eligible for Medicare, then the Eligible Retiree and/or the Eligible Dependent(s) will receive the same health insurance coverage as active employees and their dependents subject to the limitations below. The Eligible Retiree's share of premiums for the Eligible Retiree's health insurance coverage will be the same as those paid by active employees for similar coverage. In the event CalOptima is unable to reasonably obtain health insurance coverage for the Eligible Dependent(s) who are not Medicare eligible, CalOptima may provide a stipend to the Eligible Dependent(s) in lieu of health insurance coverage in an amount calculated based on the proportional amount CalOptima pays for the most closely analogous active employee health insurance coverage for active employees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima would have paid for the most closely analogous health insurance coverage for the Eligible Dependent(s). Proof of coverage, along with evidence of payments for health care coverage, must be submitted to CalOptima in order for the stipend to be paid.

2. *Medicare Eligible*: If the Eligible Retiree and/or the Eligible Dependent(s) is/are Medicare eligible, then the Eligible Retiree and/or the Eligible Dependent(s) will be required to enroll, at the Eligible Retiree's expense, in Medicare Part A and/or Part B, as a condition of receiving retiree health benefits under this policy. Proof of Medicare coverage must be submitted to Human Resources. The Eligible Retiree may select one (1) of the Medicare supplemental coverage options offered by CalOptima for the Medicare Eligible Retiree and/or the Eligible Dependent(s). The Eligible Retiree's share of the Medicare supplemental coverage premium will be calculated based on the same proportional amount active employees pay for the most closely analogous active employee health insurance coverage for the active employee and their

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dependents. In the event CalOptima is unable to reasonably obtain Medicare Supplemental coverage for the Eligible Dependent(s) who are Medicare eligible, CalOptima may provide a stipend to the Eligible Dependent(s) in lieu of Medicare Supplemental coverage in an amount calculated based on the proportional amount CalOptima pays for the most closely analogous Medicare supplemental coverage for Eligible Retirees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima would have paid for the most closely analogous Medicare Supplemental coverage for the Eligible Dependent(s). Proof of coverage, along with evidence of payments for Medicare Supplemental coverage, must be submitted to CalOptima in order for the stipend to be paid.

C. This retiree health benefit policy is completely voluntary on the part of CalOptima and may be amended, or terminated, by the CalOptima Board at any time in its sole discretion. This policy shall not create any vested benefits for any person, or categories of persons.

D. The Chief Executive Officer of CalOptima is charged with administering and interpreting this policy. When addressing any issue that is not dealt with in the Policy, the Chief Executive Officer shall consider and give weight to what the result would have been if CalOptima were still providing its employee health insurance through CalPERS.

E. This policy shall supersede any and all prior Board actions or policies concerning retiree health benefits.

III. PROCEDURE

A. The following provisions set forth the enrollment requirements for an Eligible Retiree to receive Retiree Health Benefits:

1. A Retired Eligible Employee must enroll him/herself and his/her Eligible Dependents within sixty (60) calendar days of the Retired Eligible Employee's Retirement Date or must wait to enroll during the annual open enrollment period applicable to active employees.

2. An Eligible Retiree must elect the Medicare coverage option he or she wants within sixty (60) calendar days of the Eligible Retiree and/or the Eligible Dependent becoming Medicare eligible and provide proof of Medicare coverage to Human Resources.

3. A Reinstated Eligible Employee must enroll within sixty (60) calendar days of his or her Subsequent Retirement Date.

4. A Survivor Dependent may continue coverage without interruption or enroll for Survivor Dependent coverage by submitting all necessary documentation within sixty (60) calendar days of the death of the Eligible Retiree.

5. Health insurance coverage options may be changed by an Eligible Retiree during the annual open enrollment period and for defined qualifying events applicable for active employees who are covered under CalOptima's employee health plan

B. Retiree health benefits coverage will begin upon one (1) of the following:

1. If an Eligible Employee enrolls within sixty (60) calendar days of separation from CalOptima and his or her Retirement Date, then the retiree health benefits coverage for the Retired Eligible Employee and the Eligible Dependent(s) will begin on the first day of the month following the

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date CalOptima timely receives the completed health enrollment forms from the Eligible Employee.

2. If the Retired Eligible Employee fails to enroll within sixty (60) calendar days of his or her Retirement Date, but subsequently enrolls during any future open enrollment period applicable for active employees, retiree health benefits coverage will begin on the following January 1.

3. Retiree health benefits coverage for an Eligible Survivor Dependent will continue uninterrupted upon submission of all required documentation or begin on the first day of the month following timely enrollment for coverage as a Survivor Dependent.

4. If a Reinstated Eligible Employee timely enrolls within sixty (60) calendar days of his or her Subsequent Retirement Date, then the retiree health benefits coverage for the Reinstated Eligible Employee and the Eligible Dependent(s) will begin on the first day of the month following the date CalOptima timely receives the completed health enrollment forms from the Reinstated Eligible Employee.

C. If an Eligible Employee separates from CalOptima before CalOptima receives notice from CalPERS that the Eligible Employee has/will become an annuitant, the Eligible Employee will be offered termination of health coverage information and a COBRA health plan continuation packet. After CalOptima receives notice from CALPERS of the Eligible Employee's retirement effective date, CalOptima will forward a packet to the Retired Eligible Employee concerning retiree health benefits. The Retired Eligible Employee must enroll him/herself and his/her Eligible Dependents within sixty (60) calendar days of the Retired Eligible Employee's Retirement Date or must wait to enroll during the next annual open enrollment period applicable to active employees. (NOTE: If the retirement effective date indicated by CalPERS is postdated to the date of separation or other earlier date, and CalOptima does not receive notice from CalPERS until more than sixty (60) calendar days after such date, the Retired Eligible Employee must wait to enroll during the next annual open enrollment period.). If the Retired Eligible Employee needs access to health coverage before the retiree health benefits coverage will begin, the Retired Eligible Employee will need to elect and pay for COBRA health plan continuation or pay for an alternative health plan until then.

D. Retiree health benefit coverage will terminate upon the following:

1. For Eligible Retirees, upon death of the Eligible Retiree.

2. For Eligible Dependents, upon death of the Eligible Retiree, unless the Eligible Dependent is an Eligible Survivor Dependent.

3. For Current Retirees and Retired Eligible Employees who are reinstated from retirement:

   a. During the period of reinstatement that ends CalPERS retirement annuity payments; and

   b. During and after the Subsequent Retirement Date if the Current Retiree and/or Retired Eligible Employee subsequently terminates employment from another state employer who provides retiree health benefits with a retiree share premium that is less than, or equal to, that being charged by CalOptima under this policy.

4. Upon the failure of an Eligible Retiree or Eligible Survivor Dependent to pay any required premiums within ninety (90) calendar days of payment due date.

5. When the CalOptima Board elects to terminate retiree health benefits, in part, or in its entirety.

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6. Upon the failure to obtain and certify Medicare coverage within ninety (90) calendar days upon the Eligible Retiree or the Eligible Dependent(s) becoming Medicare eligible.

7. Upon the failure of an Eligible Retiree or Eligible Dependent to maintain the required Medicare coverage.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	08/07/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	06/02/2016	GA.8055	Retiree Health Benefit	Administrative
Revised	11/03/2016	GA.8055	Retiree Health Benefit	Administrative
Revised	11/07/2019	GA.8055	Retiree Health Benefit	Administrative
Revised	06/04/2020	GA.8055	Retiree Health Benefit	Administrative

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IX. GLOSSARY

Term	Definition
Current Retiree	Former employee of CalOptima who: 1. Was hired before January 1, 2004; 2. Completed at least five (5) years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS); and 3. Was already receiving retiree health benefits from CalOptima on January 1, 2014.
Eligible Dependent	The current spouse, registered domestic partner, dependent child up to age 26, and/or certified disabled dependent child over age 26, of a Current Retiree, Retired Eligible Employee, or Reinstated Eligible Retiree, who: 1. Meets the definition of a dependent who is eligible for coverage under the employee health plan then maintained by CalOptima for its active employees; and 2. Has been timely enrolled for coverage under this retiree health policy by the Eligible Retiree.
Eligible Employee	A current active employee of CalOptima meeting the following criteria: 1. The most recent date of hire was before January 1, 2004, or whose initial date of hire was before January 1, 2004, and whose most recent rehire date was before December 1, 2013; 2. Completes at least five (5) years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS).
Eligible Retiree	Current Retiree, Retired Eligible Employee, Reinstated Eligible Retiree or Eligible Survivor Dependent.
Eligible Survivor Dependent	A Survivor Dependent who timely enrolls for Survivor Dependent health coverage within sixty (60) calendar days of the death of the Eligible Retiree.
Reinstated Eligible Retiree	A Current Retiree or Retired Eligible Employee whose CalPERS retirement annuity and benefits under this Policy ended due to a reinstatement from retirement as defined in Government Code §§22838 and 21190 et.seq., or successor sections, and who (i) subsequently terminates employment from another state employer who does not provide retiree health benefits with a retiree share premium that is less than or equal to that being charged by CalOptima under this Policy; (ii) once again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of such subsequent separation from employment; and (iii) timely enrolls for resumption of coverage under this Policy.

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Term	Definition
Retired Eligible Employee	Eligible Employee who: 1. Retires within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima and receives a monthly retirement allowance from CalPERS; and 2. Timely applies for retiree health benefits in accordance with this policy on and after January 1, 2014.
Retirement Date	Date Eligible Employee becomes an annuitant with CalPERS within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima.
Subsequent Retirement Date	Date Reinstated Eligible Retiree again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of separating from employment with the subsequent state employer described in that definition.
Survivor Dependent	Eligible Dependent who: 1. Survives an Eligible Retiree; and 2. Is collecting monthly survivor benefits from CalPERS that is attributable to a deceased Current Retiree, Retired Eligible Employee, or Reinstated Eligible Employee.

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FOR 20200604 BOD REVIEW ONLY

Policy ~~#~~: GA.8025
Title: **Equal Employment Opportunity**
Department: Human Resources
Section: Not Applicable

CEO Approval: ~~*Michael Schrader*~~

Effective Date: 01/05/2012
~~Last Review Date:~~ ~~02/02/17~~
~~Last~~ Revised Date: 06/04/2020

~~*Board Approved Policy*~~

I. PURPOSE

This policy outlines CalOptima's approach to Equal Employment Opportunity (EEO).

II. POLICY

A. CalOptima is an equal opportunity employer and makes employment decisions on the basis of merit. CalOptima wants to have qualified employees in every job. CalOptima prohibits unlawful Discrimination against any employee, ~~or~~ applicant for employment, or those applying for or engaged in a paid or unpaid internship or training program leading to employment with CalOptima based on race, religion, religious creed, color, national origin, ancestry, mental or physical disability, medical condition, genetic information, marital status, Sex, Sex Stereotype, gender, Gender Identity, Gender Expression, gender transition status, pregnancy, age, sexual orientation, military status, status as a disabled veteran or veteran of the Vietnam era, or any other consideration made unlawful by federal, state, or local laws. CalOptima also prohibits unlawful Discrimination based on the perception that anyone has any of those characteristics, or is associated with a person who has, or is perceived as having, any of those characteristics. All such Discrimination is unlawful and in violation of this Policy.

B. CalOptima is committed to compliance with all applicable laws providing equal employment opportunities. This commitment applies to all persons involved in CalOptima's operations and prohibits unlawful Discrimination by any employee of CalOptima~~, including supervisors and coworkers.~~ .

C. Equal employment opportunity will be extended to all persons in all aspects of the employer-employee relationship, including recruitment, or recruitment advertising, hiring, training, promotion, rates of pay or other forms of compensation, benefits, transfer, discipline, layoff, or termination, career development opportunities, and social and recreational programs.

D. CalOptima shall also include equal employment opportunity language in every contract with contractors and vendors requiring such persons and firms doing business with CalOptima to comply with all federal, state, and local equal employment opportunity laws.

E. It is the responsibility of every ~~manager and~~CalOptima employee to ~~conscientiously~~ adhere to this ~~P~~policy. Any employee with questions regarding this ~~P~~policy should discuss it with the Human Resources (HR) Department.

III. PROCEDURE

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A. No employee shall deny employment opportunity or discriminate in terms of employment because of race, religion, religious creed, color, national origin, ancestry, mental or physical disability, medical condition, genetic information, marital status, Sex, Sex Stereotype, gender, Gender Identity, Gender Expression, gender transition status, pregnancy, age, sexual orientation, military status, status as a disabled veteran or veteran of the Vietnam era, or any other consideration made unlawful by federal, state, or local laws.

B. CalOptima encourages all applicants for employment, employees, temporary employees, volunteers, and unpaid interns to report any incidents of Discrimination prohibited by this Policy immediately to their supervisor and/or Human Resources so that complaints can be quickly and fairly resolved in accordance with the procedures established in CalOptima Policy GA.8027: Unlawful Harassment. Employees, temporary employees, volunteers, and unpaid interns who violate this Policy shall be subject to progressive discipline, up to and including termination. Complaints will be confidential to the extent possible and responses will be timely.

C. Retaliation

1. CalOptima prohibits retaliation for bringing a complaint of **Discrimination** or harassment pursuant to this Policy against any person employed, seeking employment, providing contract services, or applying for or engaged in a paid or unpaid internship, volunteer capacity, or training program leading to employment with CalOptima. CalOptima also prohibits retaliation to a person that assists someone with a complaint of **Discrimination** or harassment. Retaliation may include threats, intimidation, and/or adverse actions related to employment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8000: Glossary of Terms
C. CalOptima Policy GA.8027: Unlawful Harassment
D. Government Code, §12920 and 12940 *et seq*.

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
02/02/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

~~A. 02/02/17: Regular Meeting of the CalOptima Board of Directors~~
~~B. 05/01/14: Regular Meeting of the CalOptima Board of Directors~~
~~C. 01/05/12: Regular Meeting of the CalOptima Board of Directors~~

VIII. ~~REVIEW/~~REVISION HISTORY

FOR 20200604 BOD REVIEW ONLY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	01/05/2012	GA.8025	Equal Employment Opportunity	Administrative
Revised	02/01/2014	GA.8025	Equal Employment Opportunity	Administrative
Revised	02/02/2017	GA.8025	Equal Employment Opportunity	Administrative
Revised	06/04/2020	GA.8025	Equal Employment Opportunity	Administrative

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IX.

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~~X.~~IX. GLOSSARY

Term	Definition
Discrimination	Unfair treatment of a person or group on the basis of a protected class.
Gender Expression	A person's gender-related appearance or behavior, whether or not stereotypically associated with the person's sex at birth.
Gender Identity	A person's identification as male, female, a gender different from the person's sex at birth, or transgender.
Sex	Includes the same definition as provided in Government Code section 12926 and Title 42 of the United States Code section 2000 e(k), which includes, but is not limited to, pregnancy, childbirth; breastfeeding, medical conditions related to pregnancy, childbirth, or breastfeeding, gender identity, and gender expression.
Sex Stereotype	An assumption about a person's appearance or behavior, or about an individual's ability or inability to perform certain kinds of work based on a myth, social expectation, or generalization about the individual's sex.

FOR 20200604 BOD REVIEW ONLY

Policy: GA.8025
Title: **Equal Employment Opportunity**
Department: Human Resources
Section: Not Applicable

CEO Approval: _____

Effective Date: 01/05/2012
Revised Date: 06/04/2020

I. PURPOSE

This policy outlines CalOptima's approach to Equal Employment Opportunity (EEO).

II. POLICY

A. CalOptima is an equal opportunity employer and makes employment decisions on the basis of merit. CalOptima wants to have qualified employees in every job. CalOptima prohibits unlawful Discrimination against any employee, applicant for employment, or those applying for or engaged in a paid or unpaid internship or training program leading to employment with CalOptima based on race, religion, religious creed, color, national origin, ancestry, mental or physical disability, medical condition, genetic information, marital status, Sex, Sex Stereotype, gender, Gender Identity, Gender Expression, gender transition status, pregnancy, age, sexual orientation, military status, status as a disabled veteran or veteran of the Vietnam era, or any other consideration made unlawful by federal, state, or local laws. CalOptima also prohibits unlawful Discrimination based on the perception that anyone has any of those characteristics, or is associated with a person who has, or is perceived as having, any of those characteristics. All such Discrimination is unlawful and in violation of this Policy.

B. CalOptima is committed to compliance with all applicable laws providing equal employment opportunities. This commitment applies to all persons involved in CalOptima's operations and prohibits unlawful Discrimination by any employee of CalOptima.

C. Equal employment opportunity will be extended to all persons in all aspects of the employer-employee relationship, including recruitment, or recruitment advertising, hiring, training, promotion, rates of pay or other forms of compensation, benefits, transfer, discipline, layoff, or termination, career development opportunities, and social and recreational programs.

D. CalOptima shall also include equal employment opportunity language in every contract with contractors and vendors requiring such persons and firms doing business with CalOptima to comply with all federal, state, and local equal employment opportunity laws.

E. It is the responsibility of every CalOptima employee to adhere to this Policy. Any employee with questions regarding this Policy should discuss it with the Human Resources (HR) Department.

III. PROCEDURE

A. No employee shall deny employment opportunity or discriminate in terms of employment because of race, religion, religious creed, color, national origin, ancestry, mental or physical disability, medical condition, genetic information, marital status, Sex, Sex Stereotype, gender, Gender Identity,

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Gender Expression, gender transition status, pregnancy, age, sexual orientation, military status, status as a disabled veteran or veteran of the Vietnam era, or any other consideration made unlawful by federal, state, or local laws.

B. CalOptima encourages all applicants for employment, employees, temporary employees, volunteers, and unpaid interns to report any incidents of Discrimination prohibited by this Policy immediately to their supervisor and/or Human Resources so that complaints can be quickly and fairly resolved in accordance with the procedures established in CalOptima Policy GA.8027: Unlawful Harassment. Employees, temporary employees, volunteers, and unpaid interns who violate this Policy shall be subject to progressive discipline, up to and including termination. Complaints will be confidential to the extent possible and responses will be timely.

C. Retaliation

1. CalOptima prohibits retaliation for bringing a complaint of **Discrimination** or harassment pursuant to this Policy against any person employed, seeking employment, providing contract services, or applying for or engaged in a paid or unpaid internship, volunteer capacity, or training program leading to employment with CalOptima. CalOptima also prohibits retaliation to a person that assists someone with a complaint of **Discrimination** or harassment. Retaliation may include threats, intimidation, and/or adverse actions related to employment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8000: Glossary of Terms
C. CalOptima Policy GA.8027: Unlawful Harassment
D. Government Code, §12920 and 12940 *et seq.*

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
02/02/2017	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	01/05/2012	GA.8025	Equal Employment Opportunity	Administrative
Revised	02/01/2014	GA.8025	Equal Employment Opportunity	Administrative
Revised	02/02/2017	GA.8025	Equal Employment Opportunity	Administrative

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Action	Date	Policy	Policy Title	Program(s)
Revised	06/04/2020	GA.8025	Equal Employment Opportunity	Administrative

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IX. GLOSSARY

Term	Definition
Discrimination	Unfair treatment of a person or group on the basis of a protected class.
Gender Expression	A person's gender-related appearance or behavior, whether or not stereotypically associated with the person's sex at birth.
Gender Identity	A person's identification as male, female, a gender different from the person's sex at birth, or transgender.
Sex	Includes the same definition as provided in Government Code section 12926 and Title 42 of the United States Code section 2000 e(k), which includes, but is not limited to, pregnancy, childbirth; breastfeeding, medical conditions related to pregnancy, childbirth, or breastfeeding, gender identity, and gender expression.
Sex Stereotype	An assumption about a person's appearance or behavior, or about an individual's ability or inability to perform certain kinds of work based on a myth, social expectation, or generalization about the individual's sex.

FOR 20200604 BOD REVIEW ONLY

Policy:	AA.1250Δ
Title:	**Disability Awareness and Sensitivity, and Cultural Competency Staff Training**
Department:	CalOptima Administrative
Section:	Human Resources - Training and Education
CEO Approval:	
Effective Date:	11/01/2012
Revised Date:	TBD

Applicable to:
- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☒ Administrative

For 20200604 BOD Review Only

I. PURPOSE

This policy ensures that all CalOptima Employees are knowledgeable, informed, and trained on standards for disability competency, cultural awareness, and sensitivity for all CalOptima Members, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. CalOptima shall ensure that all CalOptima staff who interact with CalOptima Members receive disability awareness and sensitivity Training, in accordance with DHCS Medi-Cal Managed Care Division (MMCD) All Plan Letter 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities, or any update or revision thereof, and the CalOptima Three-Way Contract with CMS and DHCS for Cal MediConnect.

B. CalOptima shall ensure that Employees are trained to provide Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and physical or mental disabilities - regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, gender, sexual orientation, health status, HIV/AIDS diagnosis, gender identity, or identification with any other persons or groups defined in Penal Code Section 422.56 - with access to quality health care that is delivered in a culturally competent manner.

C. On an annual basis, or as determined by CalOptima, CalOptima shall require all Employees who interact with Members to participate in an online Training regarding disability awareness and sensitivity, cultural competency, and CalOptima program-specific material.

D. CalOptima shall retain training records for a period of at least ten (10) years.

~~D.~~E. CalOptima shall make Training materials and resources available to all Employees via CalOptima's intranet and related Training sources.

~~E.~~F. CalOptima shall ensure Providers, Health Networks, and other delegated entities receive Training in accordance with CalOptima Policy EE.1103Δ: Provider Education and Training.

III. PROCEDURE

A. On an annual basis, CalOptima shall send an email notification to all Employees regarding the annual disability awareness and sensitivity, and cultural competency Training. The notification shall inform CalOptima Employees of the following:

1. Requirements regarding competency, cultural awareness, and sensitivity Training;
2. Location of Training module(s);
3. Instructions for completion of Training;
4. Training deadline; and
5. Contact number for questions related to the Training.

B. CalOptima shall run a report prior to the Training deadline to identify CalOptima Employees that have completed the Training. Employees who have not completed the Training shall be notified via email to remind them to take the required Training online.

C. Newly hired Employees will be assigned the Training upon hire.

D. Employees failing to complete the assigned Training in the required time period shall be subject to system shutdowns, as outlined in compliance desktop procedures, and possible disciplinary action.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Bridge to Reform 1115 Waiver
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 Agreement
F. CalOptima Model of Care
G. CalOptima Policy EE.1103Δ: Provider Education and Training
H. Medi-Cal Managed Care Division (MMCD) All Plan Letter 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities
I. Title 42, Code of Federal Regulations (C.F.R), §§438.3(u) and 440.262
J. Welfare and Institutions Code, §14182 (b)(5)
K. California Penal Code, §422.56

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VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
02/24/2013	Department of Health Care Services (DHCS)
02/24/2016	Department of Health Care Services (DHCS)
10/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2012	AA.1250	Competency, Cultural Awareness and Sensitivity Staff Training	Administrative Medi-Cal
Revised	10/01/2015	AA.1250Δ	Disability Awareness and Sensitivity and Cultural Competency Staff Training	Administrative Medi-Cal OneCare OneCare Connect PACE
Revised	11/01/2016	AA.1250Δ	Disability Awareness and Sensitivity, and Cultural Competency Staff Training	Administrative Medi-Cal OneCare OneCare Connect PACE
Revised	09/01/2017	AA.1250Δ	Disability Awareness and Sensitivity, and Cultural Competency Staff Training	Administrative Medi-Cal OneCare OneCare Connect PACE
Revised	08/01/2018	AA.1250Δ	Disability Awareness and Sensitivity, and Cultural Competency Staff Training	Administrative Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2019	AA.1250Δ	Disability Awareness and Sensitivity, and Cultural Competency Staff Training	Administrative Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	AA.1250Δ	Disability Awareness and Sensitivity, and Cultural Competency Staff Training	Administrative Medi-Cal OneCare OneCare Connect PACE

For 20200604 BOD Review Only

IX. GLOSSARY

Term	Definition
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.
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.
Employee	For the purposes of this policy, any and all employees of CalOptima, including all permanent and temporary employees, volunteers, and other employed personnel.
Member	An enrollee-beneficiary of a CalOptima program.
Training	For the purposes of this policy, means content delivered or deployed in the following manner as appropriate to the content and audience: 1. Internal communication tools (newsletters, emails, etc.); 2. Job Aids; 3. Face-to-face delivery; 4. Webinar Training; 5. Online content deployed on CalOptima University 6. CalOptima's InfoNet; 7. CalOptima's website Provider Portal; 8. Online content for posting on provider group or partner website for downstream education; and 9. Train-the-Trainer.

For 20200604 BOD Review Only

Policy:	AA.1250Δ
Title:	**Disability Awareness and Sensitivity, and Cultural Competency Staff Training**
Department:	CalOptima Administrative
Section:	Human Resources - Training and Education
CEO Approval:	
Effective Date:	11/01/2012
Revised Date:	TBD

Applicable to:
- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☒ Administrative

For 20200604 BOD Review Only

I. PURPOSE

This policy ensures that all CalOptima Employees are knowledgeable, informed, and trained on standards for disability competency, cultural awareness, and sensitivity for all CalOptima Members, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. CalOptima shall ensure that all CalOptima staff who interact with CalOptima Members receive disability awareness and sensitivity Training, in accordance with DHCS Medi-Cal Managed Care Division (MMCD) All Plan Letter 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities, or any update or revision thereof, and the CalOptima Three-Way Contract with CMS and DHCS for Cal MediConnect.

B. CalOptima shall ensure that Employees are trained to provide Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and physical or mental disabilities - regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, gender, sexual orientation, health status, HIV/AIDS diagnosis, gender identity, or identification with any other persons or groups defined in Penal Code Section 422.56 - with access to quality health care that is delivered in a culturally competent manner.

C. On an annual basis, or as determined by CalOptima, CalOptima shall require all Employees who interact with Members to participate in an online Training regarding disability awareness and sensitivity, cultural competency, and CalOptima program-specific material.

D. CalOptima shall retain training records for a period of at least ten (10) years.

E. CalOptima shall make Training materials and resources available to all Employees via CalOptima's intranet and related Training sources.

F. CalOptima shall ensure Providers, Health Networks, and other delegated entities receive Training in accordance with CalOptima Policy EE.1103Δ: Provider Education and Training.

III. PROCEDURE

A. On an annual basis, CalOptima shall send an email notification to all Employees regarding the annual disability awareness and sensitivity, and cultural competency Training. The notification shall inform CalOptima Employees of the following:

1. Requirements regarding competency, cultural awareness, and sensitivity Training;
2. Location of Training module(s);
3. Instructions for completion of Training;
4. Training deadline; and
5. Contact number for questions related to the Training.

B. CalOptima shall run a report prior to the Training deadline to identify CalOptima Employees that have completed the Training. Employees who have not completed the Training shall be notified via email to remind them to take the required Training online.

C. Newly hired Employees will be assigned the Training upon hire.

D. Employees failing to complete the assigned Training in the required time period shall be subject to system shutdowns, as outlined in compliance desktop procedures, and possible disciplinary action.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Bridge to Reform 1115 Waiver
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 Agreement
F. CalOptima Model of Care
G. CalOptima Policy EE.1103Δ: Provider Education and Training
H. Medi-Cal Managed Care Division (MMCD) All Plan Letter 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities
I. Title 42, Code of Federal Regulations (C.F.R), §§438.3(u) and 440.262
J. Welfare and Institutions Code, §14182 (b)(5)
K. California Penal Code, §422.56

For 20200604 BOD Review Only

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
02/24/2013	Department of Health Care Services (DHCS)
02/24/2016	Department of Health Care Services (DHCS)
10/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2012	AA.1250	Competency, Cultural Awareness and Sensitivity Staff Training	Administrative Medi-Cal
Revised	10/01/2015	AA.1250Δ	Disability Awareness and Sensitivity and Cultural Competency Staff Training	Administrative Medi-Cal OneCare OneCare Connect PACE
Revised	11/01/2016	AA.1250Δ	Disability Awareness and Sensitivity, and Cultural Competency Staff Training	Administrative Medi-Cal OneCare OneCare Connect PACE
Revised	09/01/2017	AA.1250Δ	Disability Awareness and Sensitivity, and Cultural Competency Staff Training	Administrative Medi-Cal OneCare OneCare Connect PACE
Revised	08/01/2018	AA.1250Δ	Disability Awareness and Sensitivity, and Cultural Competency Staff Training	Administrative Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2019	AA.1250Δ	Disability Awareness and Sensitivity, and Cultural Competency Staff Training	Administrative Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	AA.1250Δ	Disability Awareness and Sensitivity, and Cultural Competency Staff Training	Administrative Medi-Cal OneCare OneCare Connect PACE

For 20200604 BOD Review Only

IX. GLOSSARY

Term	Definition
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.
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.
Employee	For the purposes of this policy, any and all employees of CalOptima, including all permanent and temporary employees, volunteers, and other employed personnel.
Member	An enrollee-beneficiary of a CalOptima program.
Training	For the purposes of this policy, means content delivered or deployed in the following manner as appropriate to the content and audience: 1. Internal communication tools (newsletters, emails, etc.); 2. Job Aids; 3. Face-to-face delivery; 4. Webinar Training; 5. Online content deployed on CalOptima University 6. CalOptima's InfoNet; 7. CalOptima's website Provider Portal; 8. Online content for posting on provider group or partner website for downstream education; and 9. Train-the-Trainer.

For 20200604 BOD Review Only

Policy:	CMC.1003
Title:	**CalOptima OneCare Connect Staff Education and Training**
Department:	CalOptima Administrative
Section:	Human Resources – Training and Education
CEO Approval:	
Effective Date:	05/01/2015
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☒ Administrative

For 20200604 BOD Review Only

I. PURPOSE

This policy outlines the initial and ongoing Training and Education requirements for CalOptima Employees, temporary, contracted staff, and Members of the CalOptima OneCare Connect Member Advisory Committee (OCC-MAC) who have responsibilities related to the oversight, administration and/or delivery, or who serve CalOptima's Members participating in the OneCare Connect, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. CalOptima shall ensure the initial and on-going education and Training of all Employees and OCC MAC Members who interact directly with Members participating in OneCare Connect.

B. CalOptima shall ensure that all Employees and OCC MAC Members are trained to provide OneCare Connect Members with access to quality health care that is delivered in a cost-effective and compassionate manner.

C. Training will be provided in various educational formats including, but not limited to, distribution of documents, classroom, informational sessions, and eLearning modules, as appropriate for initial Training, on-going Training, and coordination of services.

D. The CalOptima Training for Employees will include, at a minimum:

1. An overview of the OneCare Connect program and services for all Employees upon hire, and annually thereafter, for Employees who interact directly with Members participating in OneCare Connect;

2. Member eligibility;

3. Member benefits;

4. Plan options;

Back to Agenda Back to Item

5. Benefit structure;

~~5.~~6. Plan options;

~~6.~~7. Member rights and responsibilities; and

~~7.~~8. CalOptima policies and procedures.

E. CalOptima will require all Employees to complete initial upon hire and annual educational sessions on:

1. Seniors and Persons with Disabilities (SPD), Americans with Disabilities Act (ADA) requirements, and Section 504 of the Rehabilitation Act awareness, sensitivity, and competency;

2. Cultural awareness and sensitivity in accordance with CalOptima Policy AA.1250Δ: Disability Awareness and Sensitivity, and Cultural Competency Staff Training; and

3. Health Insurance Portability and Accountability Act (HIPAA) compliance.

F. CalOptima will provide additional Training on pertinent content to specific functional areas, including but not limited to Customer Service, Personal Care Coordinators (PCC), Case Management, Grievance and Appeals, Pharmacy Management, Behavioral Health, and Long Term Services and Supports (LTSS), where required. This Training will include, at a minimum:

1. Grievance and appeals process;

2. Model of Care;

3. Interdisciplinary Care Team (ICT) role and responsibilities;

4. Care Coordination and care transitions;

5. Member Services;

6. Behavioral Health Services;

7. Long Term Services and Supports (LTSS); and

8. In-Home Support Services (IHSS).

G. CalOptima will provide information and Training to the OCC-MAC. The Training will include, at a minimum:

1. An overview of the OneCare Connect program and services;

2. Member eligibility;

3. Member benefits;

4. Member rights and responsibilities; and

5. CalOptima policies and procedures.

For 20200604 BOD Review Only

H. In addition to the education and Training elements described in this policy, Members of the OCC-MAC shall also be provided a copy of CalOptima Policy CMC.1007: OneCare Connect Member Advisory Committee. CalOptima will provide new OCC-MAC Members with a new Member orientation that covers all the processes described in CMC.1007: OneCare Connect Member Advisory Committee.

I. CalOptima shall make available to all staff Training materials and resources.

J. CalOptima shall ensure that Training for Providers, Health Networks, and other delegated entities is provided, in accordance with CalOptima Policy EE.1103Δ: Provider Education and Training.

K. CalOptima shall retain training records for a period of at least ten (10) years.

III. PROCEDURE

A. Upon hire, Training for CalOptima Employees will be conducted as follows:

1. During on-boarding, New Employee Orientation and/or Boot Camp.

    a. Required OneCare Connect Program Overview, Disability Awareness and Sensitivity, Cultural Competency, and HIPAA compliance Training will be completed within thirty (30) calendar days of start date.

B. Annual Training for CalOptima staff will be planned and conducted each year as follows:

1. All CalOptima Employees will complete the required Disability Awareness and Sensitivity, Cultural Competency, and HIPAA Compliance Training.

2. CalOptima shall notify all staff regarding the annual Training requirements. The notification shall inform CalOptima staff of the following:

    a. DHCS's requirement regarding competency, cultural awareness, and sensitivity Training;

    b. Specific requirements for HIPAA;

    c. OneCare Connect Training requirements for Employees who interact directly with Members participating in CalOptima OneCare Connect;

    d. Location of Training module(s);

    e. Instruction for completion of Training;

    f. Training deadline; and

    g. Contact number for questions related to the Training.

C. CalOptima shall maintain documentation of Training completed by each Employee.

D. CalOptima shall run a report leading up to and after the Training deadline to identify CalOptima Employees that have completed the Training.

1. Staff who has not completed the Training near the due date shall receive reminders via e-mail or the learning management system (LMS) to complete required Training.

For 20200604 BOD Review Only

E. Employees failing to complete the assigned Training in the required time period shall be subject to system shutdowns, as outlined in compliance desktop procedures, and possible corrective action.

IV. ATTACHMENT(S)

Not Applicable

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 Policy AA.1250: Disability Awareness and Sensitivity, Cultural Competency Staff Training
C. CalOptima Policy CMC.1007: OneCare Connect Member Advisory Committee
D. CalOptima Policy EE.1103Δ: Provider Education and Training
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities
~~E.~~F. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 15-001: Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans
~~F.~~G. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 16-002: Continuity of Care
~~G.~~H. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-001: Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect
~~H. Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities~~
I. Title 42, Code of Federal Regulations (C.F.R), § 438.3(u)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2015	CMC.1003	CalOptima OneCare Connect Staff Education and Training	OneCare Connect
Revised	12/01/2015	CMC.1003	CalOptima OneCare Connect Staff Education and Training	OneCare Connect
Revised	11/01/2016	CMC.1003	CalOptima OneCare Connect Staff Education and Training	OneCare Connect
Revised	09/01/2017	CMC.1003	CalOptima OneCare Connect Staff Education and Training	OneCare Connect

For 20200604 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	08/01/2018	CMC.1003	CalOptima OneCare Connect Staff Education and Training	OneCare Connect
Revised	10/01/2019	CMC.1003	CalOptima OneCare Connect Staff Education and Training	OneCare Connect
Revised	TBD	CMC.1003	CalOptima OneCare Connect Staff Education and Training	Administrative OneCare Connect

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For 20200604 BOD Review Only

IX. GLOSSARY

Term	Definition
Behavioral Health Services	Services which encompass both Mental Health and Substance Use Disorder services.
Care Coordination	Encompasses services included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.
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.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the state in this document.
Employee	Any and all Employees of CalOptima, including all permanent and temporary Employees, volunteers, and other employed personnel.
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.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
In-Home Supportive Services (IHSS)	A program that provides in-home care for people who cannot remain in their own homes without assistance.
Interdisciplinary Care Team (ICT)	A team comprised of the Primary Care Provider and Care Coordinator, and other providers at the discretion of the Member, that work with the Member to develop, implement, and maintain the Individual Care Plan (ICP).
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. In-Home Supportive Services (IHSS); 2. Community-Based Adult Services (CBAS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled Nursing Facility services and subacute care services.
Member	A Member-beneficiary of the CalOptima OneCare Connect program.
Model of Care	A care management process which supports the unique health care needs of a population. MOCs provide the needed infrastructure to promote quality care management and care coordination processes.
OneCare Connect Member Advisory Committee (OCC-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.

For 20200604 POD Review Only

Term	Definition
Personal Care Coordinator (PCC)	A para-professional whose function is to promote coordination of care by bridging the gap between OneCare Connect and the Health Network (HN). The role of the PCC is to facilitate communication between the Member, CalOptima, the HN or CN, the Primary Care Provider (PCP) and the Interdisciplinary Care Team (ICT). The PCC assists the Member to navigate the healthcare delivery system and facilitates access to care and services.
Provider	~~A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.~~All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services
Training	Content delivered or deployed in the following manner as appropriate to the content and audience: 1. Internal communication tools (newsletters, emails, etc.); 2. Job Aids; 3. Face-to-face delivery; 4. Webinar Training; 5. Online content deployed on CalOptima University 6. CalOptima's InfoNet; 7. CalOptima's website Provider Portal; 8. Online content for posting on provider group or partner website for downstream education; and 9. Train-the-Trainer.

For 20200604 BOD Review Only

Policy:	CMC.1003
Title:	**CalOptima OneCare Connect Staff Education and Training**
Department:	CalOptima Administrative
Section:	Human Resources – Training and Education
CEO Approval:	
Effective Date:	05/01/2015
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☒ Administrative

For 20200604 BOD Review Only

I. PURPOSE

This policy outlines the initial and ongoing Training and Education requirements for CalOptima Employees, temporary, contracted staff, and Members of the CalOptima OneCare Connect Member Advisory Committee (OCC-MAC) who have responsibilities related to the oversight, administration and/or delivery, or who serve CalOptima's Members participating in the OneCare Connect, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. CalOptima shall ensure the initial and on-going education and Training of all Employees and OCC MAC Members who interact directly with Members participating in OneCare Connect.

B. CalOptima shall ensure that all Employees and OCC MAC Members are trained to provide OneCare Connect Members with access to quality health care that is delivered in a cost-effective and compassionate manner.

C. Training will be provided in various educational formats including, but not limited to, distribution of documents, classroom, informational sessions, and eLearning modules, as appropriate for initial Training, on-going Training, and coordination of services.

D. The CalOptima Training for Employees will include, at a minimum:

1. An overview of the OneCare Connect program and services for all Employees upon hire, and annually thereafter, for Employees who interact directly with Members participating in OneCare Connect;

2. Member eligibility;

3. Member benefits;

4. Plan options;

5. Benefit structure;

6. Plan options;

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8. CalOptima policies and procedures.

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2. Cultural awareness and sensitivity in accordance with CalOptima Policy AA.1250Δ: Disability Awareness and Sensitivity, and Cultural Competency Staff Training; and

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F. CalOptima will provide additional Training on pertinent content to specific functional areas, including but not limited to Customer Service, Personal Care Coordinators (PCC), Case Management, Grievance and Appeals, Pharmacy Management, Behavioral Health, and Long Term Services and Supports (LTSS), where required. This Training will include, at a minimum:

1. Grievance and appeals process;

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3. Interdisciplinary Care Team (ICT) role and responsibilities;

4. Care Coordination and care transitions;

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6. Behavioral Health Services;

7. Long Term Services and Supports (LTSS); and

8. In-Home Support Services (IHSS).

G. CalOptima will provide information and Training to the OCC-MAC. The Training will include, at a minimum:

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2. Member eligibility;

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4. Member rights and responsibilities; and

5. CalOptima policies and procedures.

For 20200604 BOD Review Only

H. In addition to the education and Training elements described in this policy, Members of the OCC-MAC shall also be provided a copy of CalOptima Policy CMC.1007: OneCare Connect Member Advisory Committee. CalOptima will provide new OCC-MAC Members with a new Member orientation that covers all the processes described in CMC.1007: OneCare Connect Member Advisory Committee.

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J. CalOptima shall ensure that Training for Providers, Health Networks, and other delegated entities is provided, in accordance with CalOptima Policy EE.1103Δ: Provider Education and Training.

K. CalOptima shall retain training records for a period of at least ten (10) years.

III. PROCEDURE

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1. During on-boarding, New Employee Orientation and/or Boot Camp.

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B. Annual Training for CalOptima staff will be planned and conducted each year as follows:

1. All CalOptima Employees will complete the required Disability Awareness and Sensitivity, Cultural Competency, and HIPAA Compliance Training.

2. CalOptima shall notify all staff regarding the annual Training requirements. The notification shall inform CalOptima staff of the following:

    a. DHCS's requirement regarding competency, cultural awareness, and sensitivity Training;

    b. Specific requirements for HIPAA;

    c. OneCare Connect Training requirements for Employees who interact directly with Members participating in CalOptima OneCare Connect;

    d. Location of Training module(s);

    e. Instruction for completion of Training;

    f. Training deadline; and

    g. Contact number for questions related to the Training.

C. CalOptima shall maintain documentation of Training completed by each Employee.

D. CalOptima shall run a report leading up to and after the Training deadline to identify CalOptima Employees that have completed the Training.

1. Staff who has not completed the Training near the due date shall receive reminders via e-mail or the learning management system (LMS) to complete required Training.

For 20200604 BOD Review Only

E. Employees failing to complete the assigned Training in the required time period shall be subject to system shutdowns, as outlined in compliance desktop procedures, and possible corrective action.

IV. ATTACHMENT(S)

Not Applicable

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
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I. Title 42, Code of Federal Regulations (C.F.R), § 438.3(u)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2015	CMC.1003	CalOptima OneCare Connect Staff Education and Training	OneCare Connect
Revised	12/01/2015	CMC.1003	CalOptima OneCare Connect Staff Education and Training	OneCare Connect
Revised	11/01/2016	CMC.1003	CalOptima OneCare Connect Staff Education and Training	OneCare Connect
Revised	09/01/2017	CMC.1003	CalOptima OneCare Connect Staff Education and Training	OneCare Connect
Revised	08/01/2018	CMC.1003	CalOptima OneCare Connect Staff Education and Training	OneCare Connect
Revised	10/01/2019	CMC.1003	CalOptima OneCare Connect Staff Education and Training	OneCare Connect

For 20200604 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	TBD	CMC.1003	CalOptima OneCare Connect Staff Education and Training	Administrative OneCare Connect

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For 20200604 BOD Review Only

IX. GLOSSARY

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Employee	Any and all Employees of CalOptima, including all permanent and temporary Employees, volunteers, and other employed personnel.
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.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
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Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. In-Home Supportive Services (IHSS); 2. Community-Based Adult Services (CBAS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled Nursing Facility services and subacute care services.
Member	A Member-beneficiary of the CalOptima OneCare Connect program.
Model of Care	A care management process which supports the unique health care needs of a population. MOCs provide the needed infrastructure to promote quality care management and care coordination processes.
OneCare Connect Member Advisory Committee (OCC-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.

For 20200604 POD Review Only

Term	Definition
Personal Care Coordinator (PCC)	A para-professional whose function is to promote coordination of care by bridging the gap between OneCare Connect and the Health Network (HN). The role of the PCC is to facilitate communication between the Member, CalOptima, the HN or CN, the Primary Care Provider (PCP) and the Interdisciplinary Care Team (ICT). The PCC assists the Member to navigate the healthcare delivery system and facilitates access to care and services.
Provider	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services
Training	Content delivered or deployed in the following manner as appropriate to the content and audience: 1. Internal communication tools (newsletters, emails, etc.); 2. Job Aids; 3. Face-to-face delivery; 4. Webinar Training; 5. Online content deployed on CalOptima University 6. CalOptima's InfoNet; 7. CalOptima's website Provider Portal; 8. Online content for posting on provider group or partner website for downstream education; and 9. Train-the-Trainer.

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2

For 20200604 BOD Review Only

Policy ~~#~~:	GA.8057
Title:	**Compensation Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/2014
~~Last Review Date:~~	~~07/18~~
Revised Date:	06/04/2020~~06/07/18~~

I. PURPOSE

This policy establishes a compensation program for CalOptima job classifications within clearly defined guidelines that promote consistent, competitive and equitable pay practices.

II. POLICY

A. CalOptima's compensation program is intended to:

1. Provide fair compensation based on organization and individual performance;
2. Attract, retain, and motivate employees;
3. Balance internal equity and market competitiveness to recruit and retain qualified employees; and
4. Be mindful of CalOptima's status as a public agency.

B. The Chief Executive Officer (CEO), in conjunction with the Executive Director of Human Resources, is directed to administer the compensation program consistent with the attached Compensation Administration Guidelines, which ~~is a document that~~ defines the principles upon which CalOptima's compensation practices will be managed, procedural aspects of how the compensation ~~administration~~ procedures will be administered, and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay rates based on the market 50th percentile.

~~2.~~ Determining appropriate pay rates within the pay range for a position by assessing an employee's or applicant's knowledge, skills, experience, and ~~current pay level, as well as~~the pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere within the pay range based on proficiency levels. The following criteria shall be considered:

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Minimum (Min)	The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations
Midpoint (Mid) aka: 50th percentile	The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations
Maximum (Max)	The maximum rate paid to individuals who possess qualifications significantly above market norms & consistently deliver superior performance

~~4.~~3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, unless the minimum job requirements are not met, then a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months.

~~5.~~4. Base pay for all employees shall be capped at the pay range maximum, and once an employee reaches the base pay maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus provided that the employee's performance warrants this additional compensation.

C. The ~~Chief Executive Officer (~~CEO~~)~~ is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration ~~Guideline~~Guidelines not inconsistent therewith.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. Compensation Administration Guidelines

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8057	Compensation Program	Administrative
Revised	06/07/2018	GA.8057	Compensation Program	Administrative
Revised	06/04/2020	GA.8057	Compensation Program	Administrative

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IX. GLOSSARY

Not Applicable

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Compensation Administration Guidelines

~~Pay administration guidelines~~

Revised June 04, 2020

Implemented March 29, 2020

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Pay Administration Guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These ~~guidelines:~~

- ~~Help~~*Guidelines help maintain the integrity of the base pay program by introducing a common set of standards*

~~Assist~~ *and assist managers in ongoing compensation program administration.*

In addition, note the following administration of the Guidelines:

- Chief Executive Officer (CEO) compensation will be established by the Board of Directors.
- Chief and Executive Director compensation will be established by the CEO within ~~proposed guidelines~~the Guidelines.
- The Board will be informed of all Chief and Executive Director hires and compensation changes.

Proposed Pay Administration Guidelines

~~***Pay ranges and pay levels***~~

- ~~Pay range targets~~
- ~~Range minimums and maximums~~

Pay ranges and pay levels

- ~~Pay range thirds~~
- ~~Pay range halves~~
- ~~Compa-ratio~~

~~***Periodic pay adjustments/increases***~~

- ~~New hire/Rehire~~
- ~~Promotion~~

Pay range target Range minimums and maximums Pay above range maximums Pay range thirds Pay range halves Compa-ratio

- ~~Demotion~~
- ~~Temporary assignment~~
- ~~Secondary job~~

Periodic pay adjustments/increases	New hire/Rehire Promotion Lateral Transfer Demotion Temporary Assignment Secondary job Job Re-evaluation Appeal Process Register/Certified Status Base pay program maintenance Salary structure adjustment Annual competitive assessment Market sensitive jobs
Annual pay adjustments/increases	Market Adjustment Merit pay Step increase
Special one-time pay considerations	Recruitment incentive

- ~~Market adjustment~~
- ~~Merit pay~~
- ~~Step increase~~
- ~~Base pay program maintenance~~
- ~~Salary structure adjustment~~
- ~~Annual competitive assessment~~
- ~~Market sensitive jobs~~

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- ~~***Annual pay adjustments/increases***~~
- ~~Register/Certified status~~

- ~~***Special one-time pay considerations***~~
- ~~Recruitment incentive~~

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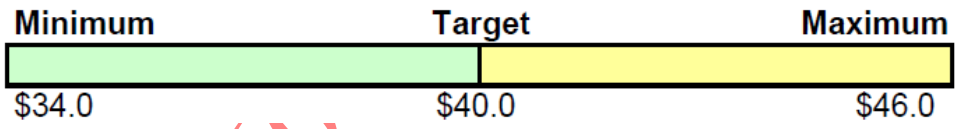
Pay Ranges and Pay Levels

Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job's requirements and performance expectations.

- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets.



- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact.



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations.

- All employees should have a pay rate equal to or greater than the pay range minimum.
- If the minimum job requirements are not met, a training rate equal to ten percent (10~~%~~%) below the salary grade minimum may be used for six (6) months while a new incumbent is learning the skills to become proficient in the new role.

Range Maximum: represents the maximum rate paid to individuals who ~~posses~~possess qualifications significantly above market norms and consistently deliver superior performance.

- Base pay growth is capped at the pay range maximum.

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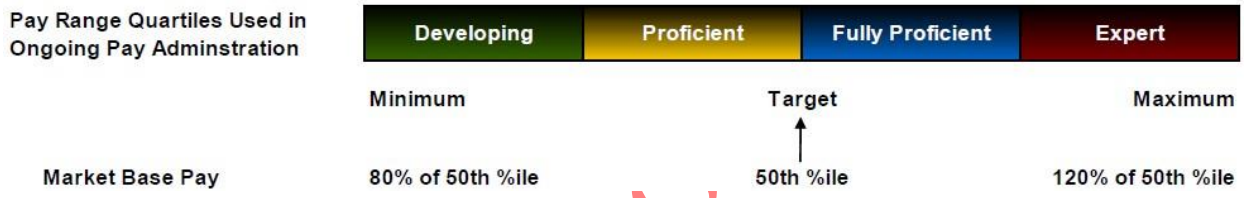
Pay Above Range Maximum: ~~as a rule, employees~~ Employees are not ~~to be~~ paid above the range maximum.

- Employees ~~paid~~whose current pay becomes above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases until such time as their base pay falls below the pay range maximum.
- In lieu of future base pay increases, these ~~individuals~~employees may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation.
- As the pay structures and pay ranges move ~~(~~every twelve (12~~—~~) – thirty-six (36) months or as necessary~~)~~, the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate.

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable, and appropriate pay levels



- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations.
- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate one hundred percent (100~~%~~%) proficiency in all aspects of the job's duties, responsibilities and performance expectations.
- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills, or abilities that far surpass the market's typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities, and performance expectations.

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness.

- Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target.
- Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate.

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- Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target.

- Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target.

Illustrative Range Shown Below:

	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

Note: *Range minimums and maximums will be based on the developed salary range spreads.*

	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

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Annual Pay Adjustments/Increases

Market Adjustment: A market adjustment is an increase or decrease to pay range ~~rates~~grades based on market pay practices.

- A market adjustment ~~results~~may result in base pay increases for full-time, part-time, and some as- needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target~~)~~).
    - For some market-sensitive jobs, a market adjustment may also be granted to full-time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression.
- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum.
    - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10~~%)~~%).

~~**Market Adjustment:**~~

- The appropriateness of a market adjustment is determined based on:
    1. A competitive assessment of the pay range target versus market base pay practices;
    2. Market trends and practices relative to average base pay and pay range increases; and
    3. Current recruiting and retention issues.
- ~~Market adjustments are made prior to determining merit pay~~

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- .

- Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target.

Base Pay Adjustment: All employees who achieve a satisfactory level of performance will be eligible for a merit pay adjustment.

- Merit Pay: Merit pay is variable pay that typically affects ~~individuals'~~employees' base pay; it recognizes ~~individuals'~~employees' job proficiency and performance of job duties.

    - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay.

    - To be eligible for merit pay, the employee must have started work on or before March ~~31st~~31 to be eligible for a merit increase in July of the same year and have successfully completed the introductory period [three (3) months for transfers and new hires~~)~~] prior to the annual pay adjustment date.

    - Merit pay will typically be an increase to base pay; however, it may also be delivered as a ~~onetime~~one-time lump sum bonus for individuals paid above the pay range maximum.

    - The budgeted amount for merit pay, if any, is based on~~:~~ 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues.

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity.

    - Merit pay is typically calculated as a percent of base pay in effect on March 31, prorated to reflect the number of months an employee worked ~~and the salary earned~~ during ~~those months~~the twelve (12)-month period starting from the first pay period in the fiscal year and ending with the last pay period of that same fiscal year.

    - Managers have the discretion to determine the actual increase amount within the published ~~guidelines~~Guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives.

    - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in two (2) incremental amounts- the first half when merit pay is normally distributed; and the second half six (6) months later.

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- Merit pay may be held altogether or delayed for ninety (90) days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record.
- Merit pay is typically awarded once a year at a specific time.
- Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at the same time.
- Executive Directors and Chief's must approve merit pay increases for all areas for which they are responsible ~~for~~ before submitting to HR.
- HR has final approval of all merit increases.

A Merit Pay Grid similar to the one shown below ~~([~~assumes a three percent (3~~%~~%) merit increase budget~~)~~] is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; ~~and.~~
4. Recruiting and retention issues.

	Pay Range Position				
Performance Rating	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	Above Max
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%
Needs Improvement	0%	0%	0%	0%	0%

Above Max = Lump Sum Bonus

** ~~**~~*The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.*

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay.
- The increase may be ~~held all together~~withheld altogether or delayed ninety (90) days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be ~~retro-active~~retroactive; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase.
- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above.

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Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to fifteen percent (15%%) of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima.
    - Recruitment incentives require the approval of the CEO.
    - Board approval is required for recruitment incentives offered to Executive Director and above positions.

Incentives are provided with a "pay-back" provision if the employee terminates within twenty four (24) months of hire.

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New Hires/Rehires

- A new hire's pay level ~~should correspond~~corresponds to the appropriate pay range ~~but~~quartile and typically should not exceed the pay range target~~; offers~~. Offers above the pay range target require the approval of the ~~Compensation Analyst in consultation with the~~ Executive Director of Human Resources~~,~~ and the CEO, when necessary.

- Factors to be considered in determining an appropriate pay level for a new hire include:

    - Job-related experience: ~~what~~What is the estimated learning curve given the individual's prior work experience? How many years of experience does the individual have in the same or equivalent classification?

    - Market conditions: ~~what~~What is the going rate of pay in the external market for the individual's skills and knowledge?

    - Internal equity: ~~is~~Is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service.

    - For example, an RN having three (3) years of prior job experience is viewed comparably to an RN having three (3) years of job experience at CalOptima.

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions.

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications.

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate~~)~~).

- Determine appropriate pay rate by assessing candidate's knowledge, skills, and experience, ~~current pay level,~~ as well as pay rates currently being paid to similarly situated incumbents.

- Candidates with superior knowledge, skills, and experience can be paid above the pay range midpoint~~; starting~~. Starting pay rates above the pay range midpoint must have approval of the ~~appropriate Compensation Analyst,~~ Executive Director of Human Resources~~,~~ and CEO ~~approval~~, when necessary.

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical~~)~~).

- Pay rates for all ~~management~~ positions ~~must be~~are reviewed with the Compensation ~~Analyst~~Unit before an offer is made. The Compensation ~~Analyst~~Unit will review internal

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equity across the system to ensure that the appropriate offer is made.

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- ~~Any questions or concerns about new hire offers should be directed to the Compensation Analyst or Executive Director of Human Resources. The Compensation Analyst will review any concerns with the Executive Director of Human Resources as necessary~~

- Rehires to the same ~~position~~classification should be paid at least the same amount they earned prior to termination, with adjustments and/or credit for recent additional career experience or education earned while away from CalOptima.
- The above policy applies to the current organization structure.
- Additional positions at the level of Chief or Executive Director require Board approval~~:~~.

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Promotion

~~Promotion:~~ An employee receives a promotion when ~~he/she~~the employee applies for and is selected for a job with a higher pay range target.

- An employee will receive a promotional increase to at least the pay range minimum of ~~his/her~~the new pay range.
- The amount of a promotional increase will ~~vary and the actual amount will~~ be determined based on the incumbent's qualifications, performance, and ~~the~~ internal pay practices ~~of other similarly-situated employees.~~. The typical promotional increase for a promotion without external competition is ~~4%~~up to ~~5% of~~five percent (5%) of the employee's base pay ~~for~~per one (1) pay grade increase.
- Typically, the promotional increase should not exceed the pay range target.
- When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Employees who are promoted after March 31, but prior to receiving their merit increase, will have their merit increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance evaluation rating and therefore merit increase amount is not known at the time the promotional pay is being calculated, a merit increase equivalent to "Fully Meets Expectations" will be included in the base pay used to calculate their promotional pay.
- The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.

Lateral Transfer

~~Lateral transfer:~~ It is considered a lateral transfer if an employee moves to a job having the same pay range target.

- Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the ~~Compensation Analyst and~~ Executive Director of Human Resources.

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- Employees who are laterally transferred after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Demotion

Demotion: An employee is classified as having been demoted if he/shethe employee moves to a job with a lower pay range target.

- AnThe pay of an employee demoted due to an organizational restructure, no pay decrease will not be givendecreased unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.
    - AnFor an involuntary demotion, due to performance will follow the guidelines below , or for reducing base pay
    - Aa voluntary demotion based on an application for an open position will typically result in a pay decrease between 0 – 4% for each salary, the pay grade of the demoted
- The demoted employee will be assigned to the pay grade of the employee's new classification. The employee's base pay will typically be reduced to the next lower pay grade. Target, or up to five percent (5%) for each pay grade maximum, whichever is appropriate using the 0 – 4% guideline abovedemoted.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.
- Employees who are demoted after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Temporary Assignment

Temporary assignment: An employee who is asked to assume a full-time temporary assignment in a job having a higher pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase.

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate.
- This increased secondary pay rate is eliminated when the temporary assignment ends.
- The amount of the temporary assignment increase should be consistent with the promotion policy.

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Training/Transition Overlap

In order to provide for a transition and/or training period, CalOptima may fill a regular position with a replacement in advance of the separation of a terminating employee. For the transition and/or training period, two employees may fill the same budgeted position for up to thirty (30) calendar days during the period of overlap. The immediate supervisor will determine which employee will be designated for decision-making and regulatory reporting purposes, if applicable.

Job Re-Evaluations

~~Job Re-Evaluations:~~ Job re-evaluations will be reviewed in the following priority order:

1. New Positions.
2. Change of thirty-five percent (35~~%~~%) or more of duties ~~([~~any change in responsibilities less than thirty-five percent (35~~%~~%) will not be considered~~)]~~.
    - Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification.

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- Additional duties that do not require the above will not be considered for reclassification.
- All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation ~~Analyst~~Unit.
- In the case of management positions being re-classified, the appropriate Chief must sign the documentation.
- The request must include the incumbent's current job description and revised job description with enhancements highlighted.
- The request must also include justification that the re-classification supports a business need.

If the job is determined to be a priority, the Compensation ~~Analyst~~Unit will analyze the job according to:

1. The job's scope against other jobs in the same discipline.
2. Available market data.
3. Appropriate title identification. The Compensation ~~Analyst~~Unit will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended.
4. Job family.
5. Fair Labor Standards Act (FLSA) status.
6. Appropriate pay grade – the job will be fit into one (1) of the pay grades that currently exists ~~– there will be no~~. No new pay grades created.
7. A pay rate will be determined.
8. A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager.

- If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date
- . The manager will be informed of the decision to move the job to a higher pay grade by the Compensation ~~Analyst~~
- Unit. The amount of the pay increase should follow the guidelines in the ~~promotion~~Promotion section

. If the upgrade and a pay change ~~occurs~~occur less than six (6) months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated.

If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive

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Director of Human Resources.

If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed.

If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed.

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Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one (1) month of the request.

If a job is not a priority or does not meet the guidelines, the manager will be notified.

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Base Pay Program Maintenance

Salary Structure Adjustment

- The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness.
- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate, and retain the workforce.
- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data.
- Market adjustments will be applied to the salary schedule as needed at least every two (2) years, using surveyed salary structure adjustment percentages.
- The salary structure adjustment approval process includes:
    - The Executive Director of Human Resources makes a recommendation to the CEO for approval.
    - CEO takes the recommendation to the Board for final approval.

Annual Competitive Assessment

- On ~~an annual~~a regular basis either annually or every other year, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices.
    - CalOptima will on a regular basis either annually or every other year spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates.
    - Based on market findings, the pay grade and ranges will be updated.
    - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations.
- The results of these analyses, along with CalOptima's current financial performance and economic situation, will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets.
- The following criteria is typically used to determine which jobs to market price each year:
    - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues~~;~~.
    - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and

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expenses to identify jobs with potential recruiting issues~~;~~.

- Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues~~;~~.

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- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%%.
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%%.
- Review all market-sensitive jobs and those on the "watch list"."
- Review top ten (10) highest populated jobs on an annual basis.
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced.
- It is recommended that at least two (2) jobs be selected from every pay range.

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends.

- Each yearOn a regular basis either annually or every other year, the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments.
- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process.
    - Adjustments to pay range minimums occur prior to merit pay calculations.

Process for Making Market Adjustments

- HR performs an annual, on a regular basis either annually or every other year, a review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs.
- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues.
- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount.
- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.).).
- HR identifies the cost implications for the market adjustment by identifying the difference between: 1) current pay rates and new pay range minimums, and, 2) current pay rates.

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- The market adjustment approval process will work as follows:
    - The Executive Director of Human Resources recommends an adjustment to the CEO for approval.
    - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the ~~position~~classification as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

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Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging.

- Premium pay is built into the pay range targets for these jobs.
    - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need.
    - The desired market target rate is established on a job-by-job basis to reflect specific market conditions.
- Criteria used to determine if a job is classified as market-sensitive typically includes two (2) or more of the following:
    - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions.
    - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates.
    - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last three (3) to six (6) months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs.
    - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:
        - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,
        - a competitive market rate significantly higher ~~([~~approximately ten percent (10~~%)~~%)~~]~~ than its current pay range target, or
        - a competitive market rate with significantly higher pay practices ~~([~~approximately ten percent (10~~%)~~%)~~]~~ in the labor market than the average of current internal pay practices.
- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.
- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies.
    - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one (1) year.
    - When a job is no longer considered market-sensitive, the job's pay range and grade

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is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time.

- Throughout the year, jobs that are not yet considered market sensitive, but are showing signs of becoming so are placed on a "watch list" and monitored.
    - If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

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Policy: GA.8057
Title: **Compensation Program**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader

Effective Date: 05/01/2014
Revised Date: 06/04/2020

I. PURPOSE

This policy establishes a compensation program for CalOptima job classifications within clearly defined guidelines that promote consistent, competitive and equitable pay practices.

II. POLICY

A. CalOptima's compensation program is intended to:

1. Provide fair compensation based on organization and individual performance;

2. Attract, retain, and motivate employees;

3. Balance internal equity and market competitiveness to recruit and retain qualified employees; and

4. Be mindful of CalOptima's status as a public agency.

B. The Chief Executive Officer (CEO), in conjunction with the Executive Director of Human Resources, is directed to administer the compensation program consistent with the attached Compensation Administration Guidelines, which defines the principles upon which CalOptima's compensation practices will be managed, procedural aspects of how the compensation procedures will be administered, and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay rates based on the market 50th percentile.

2. Determining appropriate pay rates within the pay range for a position by assessing an employee's or applicant's knowledge, skills, experience, and the pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere within the pay range based on proficiency levels. The following criteria shall be considered:

Minimum (Min)	The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations
Midpoint (Mid) aka: 50th percentile	The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations

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Maximum (Max)	The maximum rate paid to individuals who possess qualifications significantly above market norms & consistently deliver superior performance

3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, unless the minimum job requirements are not met, then a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months.

4. Base pay for all employees shall be capped at the pay range maximum, and once an employee reaches the base pay maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus provided that the employee's performance warrants this additional compensation.

C. The CEO is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration Guidelines not inconsistent therewith.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. Compensation Administration Guidelines

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative

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Action	Date	Policy	Policy Title	Program(s)
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8057	Compensation Program	Administrative
Revised	06/07/2018	GA.8057	Compensation Program	Administrative
Revised	06/04/2020	GA.8057	Compensation Program	Administrative

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IX. GLOSSARY

Not Applicable

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Compensation Administration Guidelines

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Revised June 04, 2020

Implemented March 29, 2020

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Pay Administration Guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These Guidelines help maintain the integrity of the base pay program by introducing a common set of standards and assist managers in ongoing compensation program administration.

In addition, note the following administration of the Guidelines:

- Chief Executive Officer (CEO) compensation will be established by the Board of Directors.
- Chief and Executive Director compensation will be established by the CEO within the Guidelines.
- The Board will be informed of all Chief and Executive Director hires and compensation changes.

Proposed Pay Administration Guidelines

Pay ranges and pay levels	Pay range target Range minimums and maximums Pay above range maximums Pay range thirds Pay range halves Compa-ratio
Periodic pay adjustments/increases	New hire/Rehire Promotion Lateral Transfer Demotion Temporary Assignment Secondary job Job Re-evaluation Appeal Process Register/Certified Status Base pay program maintenance Salary structure adjustment Annual competitive assessment Market sensitive jobs
Annual pay adjustments/increases	Market Adjustment Merit pay Step increase
Special one-time pay considerations	Recruitment incentive

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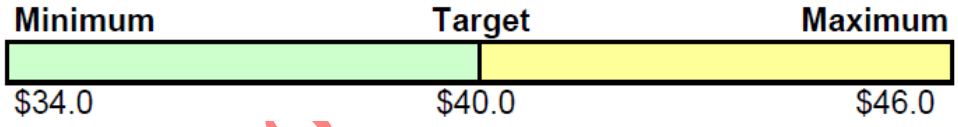
Pay Ranges and Pay Levels

Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job's requirements and performance expectations.

- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets.



- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact.



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations.

- All employees should have a pay rate equal to or greater than the pay range minimum.

- If the minimum job requirements are not met, a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months while a new incumbent is learning the skills to become proficient in the new role.

Range Maximum: represents the maximum rate paid to individuals who possess qualifications significantly above market norms and consistently deliver superior performance.

- Base pay growth is capped at the pay range maximum.

Pay Above Range Maximum: Employees are not paid above the range maximum.

- Employees whose current pay becomes above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases until such time as their base pay falls below the pay range maximum.

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- In lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation.

- As the pay structures and pay ranges move every twelve (12) – thirty-six (36) months or as necessary, the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate.

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable, and appropriate pay levels



- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations.

- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate one hundred percent (100%) proficiency in all aspects of the job's duties, responsibilities and performance expectations.

- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills, or abilities that far surpass the market's typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities, and performance expectations.

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness.

- Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target.

- Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate.

- Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target.

- Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target.

Illustrative Range Shown Below:

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	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

Note: *Range minimums and maximums will be based on the developed salary range spreads.*

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Annual Pay Adjustments/Increases

Market Adjustment: A market adjustment is an increase or decrease to pay range grades based on market pay practices.

- A market adjustment may result in base pay increases for full-time, part-time, and some as-needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target).
    - For some market-sensitive jobs, a market adjustment may also be granted to full-time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression.
- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum.
    - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10%).
- The appropriateness of a market adjustment is determined based on:
    1. A competitive assessment of the pay range target versus market base pay practices;
    2. Market trends and practices relative to average base pay and pay range increases; and
    3. Current recruiting and retention issues.
- Market adjustments are made prior to determining merit pay.
- Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target.

Base Pay Adjustment: All employees who achieve a satisfactory level of performance will be eligible for a merit pay adjustment.

- Merit Pay: Merit pay is variable pay that typically affects employees' base pay; it recognizes employees' job proficiency and performance of job duties.
    - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay.
    - To be eligible for merit pay, the employee must have started work on or before March 31 to be eligible for a merit increase in July of the same year and have successfully completed the introductory period [three (3) months for transfers and new hires] prior to the annual pay adjustment date.
    - Merit pay will typically be an increase to base pay; however, it may also be delivered

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as a one-time lump sum bonus for individuals paid above the pay range maximum.

- The budgeted amount for merit pay, if any, is based on 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues.

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity.
    - Merit pay is typically calculated as a percent of base pay in effect on March 31, prorated to reflect the number of months an employee worked during the twelve (12)-month period starting from the first pay period in the fiscal year and ending with the last pay period of that same fiscal year.
    - Managers have the discretion to determine the actual increase amount within the published Guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives.
    - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in two (2) incremental amounts- the first half when merit pay is normally distributed; and the second half six (6) months later.
    - Merit pay may be held altogether or delayed for ninety (90) days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record.
    - Merit pay is typically awarded once a year at a specific time.
    - Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at the same time.
    - Executive Directors and Chief's must approve merit pay increases for all areas for which they are responsible before submitting to HR.
    - HR has final approval of all merit increases.

A Merit Pay Grid similar to the one shown below [assumes a three percent (3%) merit increase budget] is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; and

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4. Recruiting and retention issues.

	Pay Range Position				
Performance Rating	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	Above Max
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%
Needs Improvement	0%	0%	0%	0%	0%

Above Max = Lump Sum Bonus

***The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.*

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay.

- The increase may be withheld altogether or delayed ninety (90) days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be retroactive; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase.

- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above.

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Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to fifteen percent (15%) of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima.
    - Recruitment incentives require the approval of the CEO.
    - Board approval is required for recruitment incentives offered to Executive Director and above positions.

Incentives are provided with a "pay-back" provision if the employee terminates within twenty four (24) months of hire.

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New Hires/Rehires

- A new hire's pay level corresponds to the appropriate pay range quartile and typically should not exceed the pay range target. Offers above the pay range target require the approval of the Executive Director of Human Resources and the CEO, when necessary.

- Factors to be considered in determining an appropriate pay level for a new hire include:

    - Job-related experience: What is the estimated learning curve given the individual's prior work experience? How many years of experience does the individual have in the same or equivalent classification?

    - Market conditions: What is the going rate of pay in the external market for the individual's skills and knowledge?

    - Internal equity: Is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service.

    - For example, an RN having three (3) years of prior job experience is viewed comparably to an RN having three (3) years of job experience at CalOptima.

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions.

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications.

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate).

- Determine appropriate pay rate by assessing candidate's knowledge, skills, and experience, as well as pay rates currently being paid to similarly situated incumbents.

- Candidates with superior knowledge, skills, and experience can be paid above the pay range midpoint. Starting pay rates above the pay range midpoint must have approval of the Executive Director of Human Resources and CEO, when necessary.

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical).

- Pay rates for all positions are reviewed with the Compensation Unit before an offer is made. The Compensation Unit will review internal equity across the system to ensure that the appropriate offer is made.

- Rehires to the same classification should be paid at least the same amount they earned prior to termination, with adjustments and/or credit for recent additional career experience

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or education earned while away from CalOptima.

- The above policy applies to the current organization structure.
- Additional positions at the level of Chief or Executive Director require Board approval.

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Promotion

An employee receives a promotion when the employee applies for and is selected for a job with a higher pay range target.

- An employee will receive a promotional increase to at least the pay range minimum of the new pay range.
- The amount of a promotional increase will be determined based on the incumbent's qualifications, performance, and internal pay practices. The typical promotional increase for a promotion without external competition is up to five percent (5%) of the employee's base pay per one (1) pay grade increase.
- Typically, the promotional increase should not exceed the pay range target.
- When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Employees who are promoted after March 31, but prior to receiving their merit increase, will have their merit increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance evaluation rating and therefore merit increase amount is not known at the time the promotional pay is being calculated, a merit increase equivalent to "Fully Meets Expectations" will be included in the base pay used to calculate their promotional pay.
- The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.

Lateral Transfer

It is considered a lateral transfer if an employee moves to a job having the same pay range target.

- Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the Executive Director of Human Resources.
- Employees who are laterally transferred after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Demotion

An employee is classified as having been demoted if the employee moves to a job with a lower pay range target.

- The pay of an employee demoted due to an organizational restructure, will not be decreased unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.

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- For an involuntary demotion, due to performance, or for a voluntary demotion, the pay grade of the demoted employee will be assigned to the pay grade of the employee's new classification. The employee's base pay will typically be reduced up to five percent (5%) for each pay grade demoted.

- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.

- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.

- Employees who are demoted after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Temporary Assignment

An employee who is asked to assume a full-time temporary assignment in a job having a higher pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase.

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate.

- This increased secondary pay rate is eliminated when the temporary assignment ends.

- The amount of the temporary assignment increase should be consistent with the promotion policy.

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Training/Transition Overlap

In order to provide for a transition and/or training period, CalOptima may fill a regular position with a replacement in advance of the separation of a terminating employee. For the transition and/or training period, two employees may fill the same budgeted position for up to thirty (30) calendar days during the period of overlap. The immediate supervisor will determine which employee will be designated for decision-making and regulatory reporting purposes, if applicable.

Job Re-Evaluations

Job re-evaluations will be reviewed in the following priority order:

1. New Positions.
2. Change of thirty-five percent (35%) or more of duties [any change in responsibilities less than thirty-five percent (35%) will not be considered].
    - Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification.
    - Additional duties that do not require the above will not be considered for reclassification.
    - All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation Unit.
    - In the case of management positions being re-classified, the appropriate Chief must sign the documentation.
    - The request must include the incumbent's current job description and revised job description with enhancements highlighted.
    - The request must also include justification that the re-classification supports a business need.

If the job is determined to be a priority, the Compensation Unit will analyze the job according to:

1. The job's scope against other jobs in the same discipline.
2. Available market data.
3. Appropriate title identification. The Compensation Unit will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended.
4. Job family.
5. Fair Labor Standards Act (FLSA) status.
6. Appropriate pay grade – the job will be fit into one (1) of the pay grades that currently

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exists. No new pay grades created.

7. A pay rate will be determined.

8. A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager.

If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date. The manager will be informed of the decision to move the job to a higher pay grade by the Compensation Unit. The amount of the pay increase should follow the guidelines in the Promotion section. If the upgrade and a pay change occur less than six (6) months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated.

If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director of Human Resources.

If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed.

If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed.

Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one (1) month of the request.

If a job is not a priority or does not meet the guidelines, the manager will be notified.

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Base Pay Program Maintenance

Salary Structure Adjustment

- The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness.
- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate, and retain the workforce.
- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data.
- Market adjustments will be applied to the salary schedule as needed at least every two (2) years, using surveyed salary structure adjustment percentages.
- The salary structure adjustment approval process includes:
    - The Executive Director of Human Resources makes a recommendation to the CEO for approval.
    - CEO takes the recommendation to the Board for final approval.

Annual Competitive Assessment

- On a regular basis either annually or every other year, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices.
    - CalOptima will on a regular basis either annually or every other year spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates.
    - Based on market findings, the pay grade and ranges will be updated.
    - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations.
- The results of these analyses, along with CalOptima's current financial performance and economic situation, will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets.
- The following criteria is typically used to determine which jobs to market price each year:
    - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues.
    - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and

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expenses to identify jobs with potential recruiting issues.

- Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues.
- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review all market-sensitive jobs and those on the "watch list."
- Review top ten (10) highest populated jobs on an annual basis.
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced.
- It is recommended that at least two (2) jobs be selected from every pay range.

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends.

- On a regular basis either annually or every other year, the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments.
- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process.
    - Adjustments to pay range minimums occur prior to merit pay calculations.

Process for Making Market Adjustments

- HR performs, on a regular basis either annually or every other year, a review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs.
- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues.
- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount.
- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target;

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pay range maximums = 120% of the new pay range target, etc.).

- HR identifies the cost implications for the market adjustment by identifying the difference between 1) current pay rates and new pay range minimums, and, 2) current pay rates.
- The market adjustment approval process will work as follows:
    - The Executive Director of Human Resources recommends an adjustment to the CEO for approval.
    - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the classification as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging.

- Premium pay is built into the pay range targets for these jobs.
    - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need.
    - The desired market target rate is established on a job-by-job basis to reflect specific market conditions.
- Criteria used to determine if a job is classified as market-sensitive typically includes two (2) or more of the following:
    - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions.
    - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates.
    - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last three (3) to six (6) months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs.
    - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:
        - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,
        - a competitive market rate significantly higher [approximately ten percent (10%)] than its current pay range target, or
        - a competitive market rate with significantly higher pay practices

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[approximately ten percent (10%)] in the labor market than the average of current internal pay practices.

- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.

- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies.

    - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one (1) year.

    - When a job is no longer considered market-sensitive, the job's pay range and grade is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time.

- Throughout the year, jobs that are not yet considered market sensitive, but are showing signs of becoming so are placed on a "watch list" and monitored.

If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

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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
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

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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**

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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 — **Authorized Signature**

9/25/2015 — **Date**

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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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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 June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

28. Consider Authorization of Expenditures Related to Board Membership in the National Association of Corporate Directors

Contact

Richard Sanchez, Interim Chief Executive Officer, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize expenditures of $9,800 for board membership in the National Association of Corporate Directors (NACD) for Fiscal Year (FY) 2020-21; and
2. Authorize up to $20,300 for additional seminars and related travel expenses.

Background

For more than thirty-six (36) years, NACD has worked with corporate directors to advance exemplary board leadership. It is a recognized authority on leading boardroom practices and currently helps more than 17,000 corporate directors nationwide. NACD enables corporate directors to anticipate risks and opportunities and equip them to make sound decisions based on leading practices and insights from recognized experts. Beginning in July 2015, the CalOptima Board of Directors signed up for membership in NACD, with some board members participating in NACD events.

Discussion

NACD recommends that members of the board of directors, members of executive management, and corporate secretaries participate in NACD activities. CalOptima's annual membership renewal fee of $9,800 includes membership for the full Board for the Fiscal Year (FY) 2020-21. The additional proposed expenses of $20,300 are based on prior year CalOptima expenditures for Board member seminar fees, and related travel, lodging, and meals.

Fiscal Impact

The recommended action is a budgeted item under the proposed CalOptima FY 2020-21 Operating Budget pending Board approval.

Rationale for Recommendation

CalOptima's continued membership with NACD will assist board members in remaining current on best practices in board leadership and governance.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

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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
29. Consider Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year (FY) 2020-21

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

Recommended Action
Adopt the proposed meeting schedule of the CalOptima Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee for the period July 1, 2020 through June 30, 2021.

Background
Section 5.2.(b) (1) of the CalOptima Bylaws specifies that the Board shall conduct an annual organizational meeting at a regular meeting to be designated in advance by the Board. The annual organizational meeting is scheduled for the June Board meeting each year. At the annual organizational meeting, the Board shall adopt a schedule stating the dates, times, and places of the Board's regular meetings for the following year.

Discussion
The proposed schedule of meetings for the period July 1, 2020 through June 30, 2021 is as follows:

1. The Board of Directors will meet at 2 p.m. on the first Thursday of each month, with the following exceptions:
   - Due to the Independence Day holiday, staff recommends that the Board consider not meeting in July. Should unanticipated items arise during July 2020 that requires Board review/approval, the Chief Executive Officer (CEO) will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting
   - Due to the New Year's holiday, staff recommends that the Board consider not meeting in January 2021. Should unanticipated items arise during January requiring Board review/approval, the CEO will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting.

2. The Finance and Audit Committee will meet quarterly at 2:00 p.m. on the third Thursday in the months of September, November, February and May.

3. The Quality Assurance Committee will meet quarterly at 3:00 p.m. on the third Wednesday in the months of September, November, February and May.

The meetings of the Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee are held at the CalOptima offices located at 505 City Parkway West, 1st Floor, Orange, California, unless notice of an alternate location is provided. The proposed FY 2020-21 Board of Directors Meeting Schedule is attached.

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Fiscal Impact
The fiscal impact for FY 2020-21 Board of Directors Meetings is up to $27,000 in per diem costs, and up to $9,000 in mileage reimbursement for certain Board members. Funding is included as part of the proposed CalOptima FY 2020-21 Operating Budget pending Board approval.

Rationale for Recommendation
The recommended action will confirm the Board's meeting schedule for the next fiscal year as required in Section 5.2 of the Bylaws.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Proposed Schedule of Meetings of the CalOptima Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee – July 1, 2020 through June 30, 2021

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

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CalOptima
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Proposed

Board of Directors Meeting Schedule
July 1, 2020 – June 30, 2021

All meetings are held at the following location, unless notice of an alternate location is provided:

505 City Parkway West
Orange, California 92868

Board of Directors **Monthly – First Thursday** **Meeting Time: 2:00 p.m.**	**Finance and Audit Committee** **Quarterly – Third Thursday** **Meeting Time: 2:00 p.m.**	**Quality Assurance Committee** **Quarterly – Third Wednesday** **Meeting Time: 3:00 p.m.**
*July 2020^*		
August 6, 2020		
September 3, 2020	September 17, 2020	September 16, 2020
October 1, 2020		
November 5, 2020	November 19, 2020	November 18, 2020
December 3, 2020		
*January 2021^*		
February 4, 2021	February 18, 2021	February 17, 2021
March 4, 2021		
April 1, 2021		
May 6, 2021	May 20, 2021	May 19, 2021
June 3, 2021[1]		

^No Regular meeting scheduled
[1] Organizational Meeting

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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
30. Consider Appointments to the CalOptima Board of Directors' Member Advisory Committee

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

Recommended Actions
The CalOptima Member Advisory Committee (MAC) recommends:

1. Reappointment of the following individuals to serve two-year terms on the Member Advisory Committee, effective July 1, 2020;
    a. Pamela Pimentel as the Children Representative for a term ending June 30, 2022;
    b. Sr. Mary Therese Sweeney as the Behavioral/Mental Health Representative for a term ending June 30, 2022;
    c. Sally Molnar ~~Mouton~~ as the Medical Safety Net Representative for term ending June 30, 2022; *Rev. 5/29/2020*
    d. Christine Tolbert as the Persons with Special Needs Representative for a term ending June 30, 2022;

2. Appointment of the following individuals to serve two-year terms on the Member Advisory Committee, effective July 1, 2020:
    a. Melisa Nicholson as the Foster Children Representative for a term ending June 30, 2022;
    b. Patty Mouton as the Long-Term Services and Supports Representative for a term ending June 30, 2022; and

3. Appointment of the following individual to fulfill a remaining term effective upon Board appointment:
    a. Maura Byron as the Family Support Representative for a 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 fifteen voting members. Pursuant to the resolution, MAC members serve two-year terms except for the two standing seats, which are representatives from the Social Services Agency (SSA) and the Health Care Agency (HCA). The CalOptima Board is responsible for the appointment of all MAC members.

With the fiscal year ending on June 30, 2020, seven MAC seats will expire: Children, Consumer, Foster Children, Long-Term Services and Supports, Medical Safety Net, Mental/Behavioral Health, Persons with Special Needs. Due to a resignation, MAC also recruited for a Family Support Representative during this recruitment initiative.

Discussion

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CalOptima conducted a comprehensive outreach, including sending notifications to community-based organizations (CBOs), conducted targeted community outreach to agencies and CBOs serving the various open position and posting recruitment materials on the CalOptima website. Staff also presented on the Board Advisory Committees at a Community Alliances Forum to enhance recruitment efforts.

The MAC Nominations Ad Hoc Subcommittee, composed of MAC committee members Diana Cruz-Toro, Connie Gonzalez and Mallory Vega evaluated each of the application for the impending openings and forwarded the proposed slate of candidates for the seven vacancies. MACs consumer seat will remain vacant until an eligible candidate is identified.

At the May 14, 2020 Special MAC meeting, MAC members accepted the recommended slate of candidates as proposed by the Nominations Ad Hoc and requested that the proposed slate of candidates be forwarded to the CalOptima Board for consideration

The candidates for the open positions are as follows:

Behavioral/Mental Health Candidates

Sr. Mary Therese Sweeney*
Sr. Mary Therese Sweeney is the Director of Mental Health for St. Joseph Health. She has served the mentally ill for over 20 years, especially those with limited access to services. Sr. Sweeney is sensitive to the needs of the mentally ill and believes that direct contact with those served is essential. She often visits service sites and spends considerable time talking to people with mental illness at meetings, at drop-in centers and in the community. She currently holds the Persons with Mental Illness seat on the MAC.

Donald Stukes
Donald Stukes is the Founder/Managing Director of Innovative Healthcare Solutions & Services whose mission is to improve lives with health care. A disabled veteran, Mr. Stukes is a Volunteer/Contractor/Affiliate at the Veterans Administration Medical Center in Long Beach where he advises Board members in the medical research areas on administrative and operational activities. He is also in training to provide behavioral health peer support/facilitating services. He is also an active member of the Orange County Veterans & Military Families Collaborative which represents over 103 public/private agencies to share information and currently sits on the Behavioral Health Working Group. Mr. Stukes is also an active volunteer with the Orange County Health Care Agency and a member of the California Healthcare Foundation. Mr. Stukes has been the Member Advocate on the OneCare Connect Member Advisory Committee since 2019.

Children Candidates
Pamela Pimentel*
Pamela Pimentel, RN is the former Chief Executive Officer of MOMS Orange County. MOMS Orange County provides access to prenatal care, health screenings, infant development screenings, health education and referral services through monthly home visits and group classes. Ms. Pimentel serves on several committees through the OC community, among them NIH Community Recruitment Steering Committee, Chair for Children's Research, UCI Clinical Translational Science Enterprise Leadership

*Indicates MAC recommendation

Community Advocate, Community Benefits Committee, St. Joseph Hospital, Pediatric Services Lead, Orange County Perinatal Council, Current Member and Past President, Orange County Women's Health Project Advisory Board and the Community Health Initiative Orange County, Children's Health Insurance sub-committee. She is a former member of the CalOptima Provider Advisory Committee (PAC) having served for nine consecutive years in various seats most recently as the Nurse representative. She currently serves as the Vice Chair of the MAC.

Foster Children Candidates

Melisa Nicholson*

Ms. Nicholson is a Special Medical Senior Social Worker with the Orange County Children and Family Services Social Services Agency. She works directly with foster children who have an open dependency cases in the special medical program with moderate to severe medical conditions who are on Medi-Cal through CalOptima. She collaborates with medical providers, hospital medical social works and Medi-Cal providers to ensure dependent children have medical needs met.

Kendyl King

Ms. King is a Senior Social Worker Special Medical Program and Special Medical Intake Coordinator for the Social Services Agency of Orange County. She works with special medical needs foster children and medically fragile children which include CalOptima members. She interfaces regularly with CalOptima, specifically for Medi-Cal foster children needs.

Kim Leason

Mr. Leason is a self-employed volunteer. Having lived in Orange County since 1977 and being a former recruiter for the Automobile Association of America (AAA). He now dedicates his days to volunteering and has been a community leader/volunteer for many years.

Long-Term Services and Supports Candidates

Patty Mouton*

Patty Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County and has worked in the area of health care for older adults for 17 years. Ms. Mouton oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy forming activities. In addition, Ms. Mouton speaks to community groups about issues of medical coverage and defining the continuum of care. Ms. Mouton is a current committee member of CalOptima's OneCare Connect Member Advisory Committee where she serves as its Chair. Patty currently holds the Medi-Cal Beneficiaries Representative seat on the MAC.

Kim Leason

Mr. Leason is a self-employed volunteer. Having lived in Orange County since 1977 and being a former recruiter for the Automobile Association of America (AAA). He now dedicates his days to volunteering and has been a community leader/ volunteer for many years.

Donald Stukes

Donald Stukes is the Founder/Managing Director of Innovative Healthcare Solutions & Services whose mission is to improve lives with health care. A disabled veteran, Mr. Stukes is a Volunteer/Contractor/Affiliate at the Veterans Administration Medical Center in Long Beach where he

*Indicates MAC recommendation

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advises Board members in the medical research areas on administrative and operational activities. He is an active member of the Orange County Veterans & Military Families Collaborative which represents over 103 public/private agencies to share information and currently sits on the Behavioral Health Working Group. Mr. Stukes is also an active volunteer with the Orange County Health Care Agency and a member of the California Healthcare Foundation. Mr. Stukes has been the Member Advocate on the OneCare Connect Member Advisory Committee since 2019.

Medical Safety Net Candidates

Sally Molnar*

Sally Molnar advocates for breast health screenings and treatment programs that provide a safety net for under-insured and uninsured women in Orange County. She is a past Public Policy Chair and advocated for breast cancer services at the state and federal level. She has volunteered with Susan G. Komen in Orange County for many years in various capacities. Sally currently holds the Medical Safety Net seat on the MAC and has previously served as the MAC Chair.

Erika Jewell

Ms. Jewell is the Manger of Case Management and Social Services at Children's Hospital of Orange County (CHOC) were she works closely with CHOC Health Alliance and Medi-Cal patients and families to ensure they received the Social Services support they need. Ms. Jewell is a licensed Clinical Social Worker and has managed departments and programs in community health centers and hospitals, with all age groups and individuals from a variety of ethic/socioeconomic backgrounds.

Alexander Sweidan, M.D.

Dr. Sweidan is the Medical Director for Strong Families Medical Group, an Assistant Clinical Professor of Medicine at UCI and holds the position of Associate Medical Director at Noble Mid OC IPA. Dr. Sweidan is an internal medicine and neurological/critical care physician who actively treats CalOptima members both in outpatient and hospital settings. Dr. Sweidan is a member of CalOptima's Utilization Management Committee.

Ryan Yamamoto

Mr. Yamamoto is the Chief Operating Officer for The Coalition of Orange County Community Health Centers (CoalitionOC). The CoalitionOC currently serves over 370,000 low income, underinsured and uninsured patients in the county. In addition to working with member health centers, he is responsible for establishing, developing and maintaining relationships with other non-medical safety net providers that address the social determinants of health for the underserved. Before his employment with CoalitionOC, Mr. Yamamoto has served on a national taskforce to solve homelessness in the City of Oakland for the frail and elderly and also developed a homeless patient pilot program to address uninsured homeless patients that frequent two Kaiser Permanente Medical Center Emergency Departments in Southern California.

Persons with Special Needs Candidates

Christine Tolbert*

Christine Tolbert's current work for the State Council on Developmental Disabilities has allowed her to advocate for thousands of people dealing with an expansive number of medical and/or special needs' conditions. She has helped transition people from the state hospital into the community necessitating her

*Indicates MAC recommendation

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involvement in their transition to managed care and accessing health care services. Christine currently holds the Persons with Special Needs seat and has served as the MAC Chair since 2019.

Kim Leason
Mr. Leason is a self-employed volunteer. Having lived in Orange County since 1977 and being a former recruiter for the Automobile Association of America (AAA). He now dedicates his days to volunteering and has been a community leader/volunteer for many years.

Special Recruitment

Family Support Representative Candidates
Maura Byron*
Ms. Byron is the Executive Director of the Family Support Network (FSN) and is the parent of a young adult who is a current CCS client. As the executive director, she assists 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. She is the current Chair of CalOptima's Whole-Child Model Family Advisory Committee.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy, the MAC established a Nominations Ad Hoc to review potential candidates for vacancies on the Committee. The MAC met to discuss the Ad Hoc's recommended slate of candidates and concurred with the Subcommittee's recommendations. The MAC forwards the recommended slate of candidates 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 — *05/27/2020*
Authorized Signature — **Date**

*Indicates MAC recommendation

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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

31. Consider Provider Advisory Committee Recommended Appointments to the CalOptima Board of Directors' Provider Advisory Committee

Contact

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

Recommended Actions

The CalOptima Provider Advisory Committee recommends that the Board:

1. Appoint Christy Ward as the Community Health Centers Representative, for a three-year term ending June 30, 2023.

2. Appoint Jena Jensen as the Hospitals Representative, for a three-year term ending June 30, 2023.

3. Appoint Alpesh Amin, MD, MBA, MACP, SFHM, FACC, FRCP (Lond) as the Physician Representative, for a three-year term ending June 30, 2023.

4. Appoint Alexander Rossel as the Safety Net Representative, for a three-year term ending June 30, 2023.

5. Appoint Jennifer Birdsall as an Allied Health Representative, to fulfill a remaining term through June 30, 2022.

6. Appoint Peter Korchin as an Allied Health Representative, to fulfill a remaining term through June 30, 2021.

Background

The CalOptima Board of Directors established the Provider Advisory Committee (PAC) by resolution on February 14, 1995 to provide input to the Board. The PAC is comprised of fifteen voting members. Pursuant to resolution no. 15-0806-03, PAC members serve three-year terms with the exception of one standing seat, which is occupied by a representative from the Orange County Health Care Agency (HCA). The CalOptima Board is responsible for the appointment of all PAC members. With the fiscal year ending on June 30, 2020, four PAC seats will expire: (1) Community Health Center, Hospitals, Physician and Safety Net seats. Due to a resignation and the reclassification of a Long-Term Services and Supports seat to an Allied Health Services seat, PAC also recruited for two Allied Health Services Representatives to fulfill remaining terms through June 30, 2021 and June 30, 2022.

Discussion

CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment process included notification methods including sending outreach flyers to Community based organizations (CBOs) and targeting community outreach to agencies and CBOs serving the various open positions. Recruitment also consisted of emails to physicians, health

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networks, Long-term Care Facilities, hospitals and pharmacies in order to reach all CalOptima providers for all open seats. CalOptima staff also presented on the committees and their upcoming openings at a recent Community Alliances Forum. CalOptima staff received the applications from interested candidates and submitted them to the Nominations Ad Hoc Subcommittee for review.

Prior to the Nominations Ad Hoc Subcommittee meeting on May 8, 2020, subcommittee members evaluated each of the applicants. The subcommittee, including Members Chair Nishimoto, Vice Chair Miranti and Dr. Lazo-Pearson, selected a candidate for each of the open seats and forwarded the proposed slate of candidates to the PAC for consideration.

At the May 14, 2020 meeting, the PAC voted to accept the recommended slate of candidates proposed by the Nominations Ad Hoc.

The slate of candidates are as follows:

Community Health Centers Representative

Christy Ward*

Ms. Ward is the Chief Executive Officer of Share Our Selves, a Federally Qualified Health Center (FQHC), with six FQHC sites that serve CalOptima members throughout Orange County. Ms. Ward serves as a board member for The Coalition of Orange County Community Health Centers and the California Primary Care Association. Ms. Ward holds a Masters in Communication and Organizational Leadership from Gonzaga University.

Yasamin Farhad, Ph.D., LMFT

Dr. Farhad is a licensed Marriage and Family Therapist. Currently, Dr. Farhad is the Chief Executive Officer of Congruent Lives, Inc., where she oversees the functions of a non-profit organization that provides over 1,500 sessions to patients on a monthly basis. Dr. Farhad collaborates onsite with county-wide agencies including the Orange County Social Services agency, La Habra Family Resource Center; Pathways of Hope Homeless Shelter and as well as assisting students at the California State University, Fullerton to ensure standard and continuum of care. Dr. Farhad holds a Doctor of Philosophy (Ph.D) with an emphasis on Psychotherapy for Diverse Populations and Cultural Research from The Chicago School of Professional Psychology, and a Master of Science in Counseling from California State University, Fullerton.

Bertha Schnelle

Ms. Schnelle has been with Planned Parenthood of Orange and San Bernardino Counties/Melody Women's Health since 2006 and has been their Chief Operating Officer since 2013. Ms. Schnelle oversees nine health centers with over 300 employees that service over 100,000 unique Orange County residents. She holds a Master of Business Administration, Health Care Executive program, from the University of California, Irvine, Paul Merage School of Business and graduated in the top 8% of her class. She also holds a Master of Public Health with an emphasis in Health Care Management from the University of California, Los Angeles, School of Public Health.

*Indicates PAC recommendation

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Hospitals

Jena Jensen*

Ms. Jensen has served on the PAC since 2013 as the Safety Net Representative. She is the Chief Government Relations Officer at Children's Hospital of Orange County (CHOC). CHOC has been partnering with CalOptima since the agency's inception in 1993. Ms. Jensen's 28-year tenure with CHOC began in 1992, when she joined the hospital as Director of Marketing and Public Relations. She currently serves as CHOC's central resource for legislative advocacy as well as development and maintenance of relationships with federal, state, and local elected officials, as well as government, and community and opinion leaders. Ms. Jensen served as the PAC Chair from 2014–2016.

David Kowalski

Mr. Kowalski is the Chief Executive Officer of Triad/So. California Specialty Care, which owns Kindred Healthcare. He is responsible for all Kindred Hospitals in Santa Ana, San Gabriel and La Mirada. Mr. Kowalski participates and provides leadership to numerous hospital committees. He holds a Master of Health Administration and Physical Education from Ohio University.

Pat Patton

Mr. Patton has been the Chief Nursing Officer for the University of California, Irvine Medical Center (UCI Health) since 2016. He is responsible for oversight of all nursing operations including acute, inpatient, and outpatient care, as well as ambulatory services. He is an active and valued participant on a variety of hospital committees. Mr. Patton is a member of UCI Health's Medi-Cal Strategies Committee, which is aimed at advancing population health management for UCI's Medi-Cal patients, the majority of which are CalOptima members. Mr. Patton holds a Master of Science in Nursing (MSN), specializing in nursing administration. He also holds memberships in the American Organization of Nurse Executives, American Nurses Association and Association of California Nurse Leaders. Mr. Patton is the current Hospital representative on the PAC whose term expires on June 30, 2020.

Physician Representative

Alpesh Amin, MD, MBA, MACP, SFHM, FACC, FRCP (Lond)*

Dr. Amin is the Chair of the Department of Medicine for the University of California. Irvine (UCI) and is the Founder and Executive Director of the Hospitalist Program at UCI. He is a member of the American College of Physicians where he holds the title of Governor, Southern California Region II and President, American College of Physicians for All California. Dr. Amin received his Medical Degree from Northwestern University and completed his residency and Chief Residency in Internal Medicine at UCI.

Amrit Bhangoo, M.D.

Dr. Bhangoo is a pediatric endocrinologist at Children's Hospital of Orange County (CHOC) and currently serves as Section Chair of pediatric endocrinology. Dr. Bhangoo holds certifications from the Educational Commission of Foreign Medical Graduates, the American Board of Pediatrics in General

*Indicates PAC recommendation

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Pediatrics, and the American Board of Pediatrics in Pediatric Endocrinology. He received his MBBS, Doctor of Medicine (MD), in Guru Govind Singh Medical College, Faridkot, Punjab India.

Tiffany Damikolas, M.D.
Dr. Damikolas is the site medical director of two clinics within AltaMed Health Services and a large FQHC where she participates in all audits ensuring that AltaMed is compliant with all regulatory requirements. Dr. Damikolas represents AltaMed in the Coalition of Orange County Community Health Centers and sees pediatric patients at their Santa Ana Bristol Clinic. She is Board certified in Pediatrics, received her medical degree from Boston University School of Medicine and completed her residency University of California Irvine and Children's Hospital of Orange County pediatric residency programs.

Vinh Lam, M.D.
Dr. Lam is currently with Pediatric Surgical Associates in Orange, where he is a pediatric surgeon treating a majority of CalOptima's youngest members. Dr. Lam holds a Bachelor of Science in Biological Science, graduating Magna Cum Laude from the University of Southern California. He received his medical degree from Harvard Medical School.

Derek Lanier, M.D.
Dr. Lanier is the National Chief Medical Officer at Prospect Medical Systems, Inc. He is responsible for leveraging resources and relationships with internal and external stakeholders to deliver health care to Orange County's diverse population of members. Dr. Lanier was previously the Regional Medical Director, Greater Los Angeles, Regal Medical Group/Heritage Provider Network. He received his Medical Degree at the University of Michigan School of Medicine and completed his residency at Henry Ford Health System, Department of Family Medicine Residency Program in Detroit, Michigan. Dr. Lanier is Board Certified by the American Board of Family Medicine and is licensed to practice in California, Michigan and Illinois.

Catherine Marks, M.D.
Dr. Marks is a Family Practice physician at the Saint Marya Family Medicine Clinic in Anaheim, CA. She is board certified by the American Board of Family Medicine and the American Academy of Family Medicine. She is a volunteer with the Orange County Congregation Community Organization (OCCCO), Boys and Girls Club. Children's Cause Orange County. and Orange County Human Relations. Dr. Marks received her Medical Degree from Cairo University in Egypt, completed her residency in Family Medicine at the University of Saskatchewan, Canada.

Alexander Sweidan, M.D.
Dr. Sweidan is the Medical Director for Strong Families Medical Group, Associate Medical Director at Noble Mid Orange County IPA, and Assistant Clinical Professor of Medicine at University of California, Irvine. Dr. Sweidan is an Internist and Neurological/Critical Care physician who actively treats CalOptima members both in outpatient and hospital settings. Dr. Sweidan is a member of CalOptima's Utilization Management Committee. Dr. Sweidan received his Medical Degree from Poznan University of Medical Sciences, Poznan, Poland and completed his Internal Medicine residency at St. Mary's Medical Center, Long Beach, (a UCLA affiliate) and completed his Neurological Critical

Care Fellowship at the University of California, Irvine, from which he also holds a Master of Business Administration, Health Care Executive program.

James Tran, M.D.
Dr. Tran has been a physician in the Orange County community since 2010. He is a medical and neurosurgical provider for patients in OneCare, OneCare Connect and CalOptima Direct. Dr. Tran has been a medical care provider for the homeless, patients with special needs, and children in Orange County and surrounding areas. Dr. Tran is a community member of the UC Irvine Medical Center Bioethics Committee and serves as a professor of Surgery at Western University of Health Sciences in Pomona. Dr. Tran is Board Certified by the American Association of Neurological Surgery and National Board of Medical Examiners. He obtained his Medical Degree from Loyola University Chicago, Stritch School of Medicine, and he also holds a Juris Doctor from Brigham Young University J. Reuben Clark School of Law.

Kenneth Wen, M.D.
Dr. Wen is a Non-invasive Cardiologist for Pacific Cardiovascular Associates Medical Group in Orange, where he treats many CalOptima members. Dr. Wen is a member of the Monarch Healthcare Physician Action Committee and a voluntary staff cardiologist at Fountain Valley Regional Hospital, Orange Coast Memorial Hospital, Hoag Hospital, Anaheim Regional Medical Center and Orange County Global Medical Center. He received Medical Degree from Northwestern University Feinberg School of Medicine and completed his Internal Medicine residency at Beth Israel Medical Center in New York. He also completed a Clinical Fellowship in Cardiology at the Maimonides Medical Center in Brooklyn, New York.

Safety Net Representative
Alexander Rossel*
Mr. Rossel is the Chief Executive Officer of Families Together of Orange County Community Health Center, a Federally Qualified Health Center in Orange County. Mr. Rossel is the current board president for the Coalition of Orange County Community Health Centers where he has developed relationships with other health agencies, health networks and pivotal healthcare partners. He is a member of the Salvation Army Orange County Advisory committee and a member of the California Primary Care Association. He attended the Universidad Inca Garcilazo de La Vega in Lima, Peru, majoring in Accounting.

Darya Amirshahrokhi
Mr. Amirshahrokhi is the CEO and a Board Certified Prosthetic and Orthotics practitioner at Pioneer Orthotics and Prosthetics, Inc. in Lake Forest, CA. He is a California Children's Services paneled orthotist and prosthetist and is a member of the American Board for Certification in Orthotics and Prosthetics (A.B.C.) and a member of the American Academy of Orthotists and Prosthetics. Mr. Amirshahrokhi holds a Bachelor of Science in a dual program consisting of Prosthetics and Orthotics and Electronic Engineering as well as an MBA from Tehran University, Tehran, Iran. He is fluent in both Farsi and English.

*Indicates PAC recommendation

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Pat Patton
Mr. Patton has been the Chief Nursing Officer for the University of California Irvine Medical Center since 2016. He is responsible for oversight of all nursing operations including acute care, inpatient and outpatient as well as ambulatory services. He is an active and valued participant on a variety of hospital committee. Mr. Patton is a member of UCI Health's Medi-Cal Strategies Committee, which is aimed at advancing population health management for UCI's Medi-Cal patients, the majority of which are CalOptima members. Mr. Patton holds a Master of Science in Nursing (MSN) specializing in nursing administration. He also holds memberships in the American Organization of Nurse Executives, American Nurses Association, Association of California Nurse Leaders. Mr. Patton is the current Hospital representative on the PAC whose term expires on June 30, 2020.

Leonardo Perez
Mr. Perez is the President and CEO of Quantum Consulting and Professional Services. Quantum provides in depth analysis of clinical and administrative system processes issues affecting HEDIS and HCC collection. He is also a Clinical Physician Assistant with AltaMed Health Services in Orange County. Mr. Perez is currently a fourth-year medical student at the International University Health Sciences School of Medicine and is completing his clinical rotations. He holds a Bachelor of Science in Physician Assistant Practice from the University of Southern California (USC) Keck School of Medicine.

Special Allied Health Services Representative Recruitment (two seats)
PAC received an unexpected vacancy for the Allied Health Services Representative and undertook a special recruitment in December 2019 to find qualified candidates for the seat. As part of the joint recruitment ad hoc, PAC requested at the March 5, 2020 Board of Director's meeting to reclassify a Long-Term Services and Supports Representative to an Allied Health Services Representative which was approved by Board Resolution 20-0305-02. In order to streamline the ad hoc process, PAC elected to review the applicants at the same time as the candidates from the yearly recruitment. The selected Allied Health Services Representatives will fulfill remaining terms through June 30, 2021 and June 30, 2022.

Jennifer Birdsall, Ph.D.*
Dr. Birdsall is the Clinical Director, California for CHE Health Services. Since 2014, she has had oversight of more than150 clinical psychologists in over 350 skilled nursing facilities throughout California. She also conducts clinical psychologic services for patients in long-term care settings. Dr. Birdsall holds a Doctor of Philosophy in the APA-Accredited Doctoral Program in Clinical Psychology from the University of Louisville, in Louisville, Kentucky. During her Doctoral studies she was the recipient of the Graduate Fellowship Award and the Dean's Citation Graduation Award.

Peter Korchin*
Mr. Korchin is currently the Director of Pediatric Orthotics for Inhous Orthopedics Inc., a Human Designs company where he provides in-clinic orthotic assessment and care for multiple California Children's Services Medical Therapy Units (MTU). He has 35 years of experience in fitting children with disabling conditions such as Cerebral Palsy, Spina Bifida, Muscular Dystrophy, and Traumatic Brain Injury in the Orange County area. Mr. Korchin is currently the Chief Orthotist for the Spina Bifida

*Indicates PAC recommendation

CCS Center at Miller Children's &Women's Hospital in Long Beach, where he also provides training to resident physicians in rehabilitation medicine and Orthopedics. Mr. Korchin holds a Bachelor of Science in Biology and Chemistry from the State University of New York at Albany, a Certificate of Orthotics from Northwestern University, and completed his Residency in Orthotics at Rancho Los Amigos Medical Center. He is member of the American Board for Certification in Orthotics and Prosthetics.

Darya Amirshahrokhi
Mr. Amirshahrokhi is the CEO and a Board Certified Prosthetic and Orthotics practitioner at Pioneer Orthotics and Prosthetics, Inc. in Lake Forest, CA. He is a California Children's Services paneled orthotist and prosthetist and is a member of the American Board for Certification in Orthotics and Prosthetics (A.B.C.) and a member of the American Academy of Orthotists and Prosthetics. Mr. Amirshahrokhi holds a Bachelor of Science in a dual program consisting of Prosthetics and Orthotics and Electronic Engineering as well as an MBA from Tehran University, Tehran Iran. He is fluent in Farsi and English.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in CalOptima policy AA.1219b, the PAC established a Nominations Ad Hoc to review potential candidates for vacancies on the Committee. The PAC met to discuss the recommended slate of candidates and concurred with the Subcommittee's recommendations. The PAC forwards the recommended slate of candidates to the Board of Directors for consideration.

Concurrence
Provider Advisory Committee Nominations Ad Hoc
Provider Advisory Committee
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by This Recommended Board Action

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

*Indicates PAC recommendation

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Legal Name	Address	City	State	Zip code
Allied Health Services Candidates				
Darya Amirshahrokhi	Pioneer Orthotics & Prosthetics 23672 Birtcher Dr., Unit A	Lake Forest	CA	92630
Jennifer Birdsall	CHE Health Services 4929 Wilshire Blvd. Suite 510	Los Angeles	CA	90010
Peter Korchin	Human Design Companies 15571 Brookhurst Street	Westminster	CA	92683
Community Health Centers				
Yasamin Farhad	Congruent Lives, Inc. 2601 E. Chapman Ave. Suite 102	Fullerton	CA	92831
Betha Schnelle	Planned Parenthood 700 S. Tustin St.	Orange	CA	92866
Christy Ward	Share Our Selves 20151 SW Birch St., Suite 100	Newport Beach	CA	92660
Hospitals				
Jena Jensen	CHOC 1201 W. LaVeta Ave.	Orange	CA	92868
David Kowalski	Triad/So. Cal Specialty Care (aka Kindred) 14 Miners Trail	Irvine	CA	92620
Pat Patton	UCI 101 The City Drive South	Orange	CA	92868
Physician				
Alpesh Amin, M.D.	UCI 101 The City Drive South	Orange	CA	92868
Amrit Bhangoo, M.D.	CHOC 1201 W. La Veta Ave.	Orange	CA	92868
Tiffany Damikolas, M.D.	AltaMed 2720 S. Bristol St. #110	Santa Ana	CA	92704

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Vinh Lam, M.D.	Pediatric Surgical Associates 396 Main St. #20	Orange	CA	92868
Derek Lanier, M.D.	Prospect Medical 600 City Parkway West #800	Orange	CA	92868
Catherine Marks, M.D.	Saint Marya Family Medicine Clinic 3400 W. Ball Road, Suite 202	Anaheim	CA	92804
Alexander Sweidan, M.D.	Noble Medical Group 2222 S. Main St.	Santa Ana	CA	92707
James Tran, M.D.	James T. Tran MD Corp. 13031 Kerry St.	Garden Grove	CA	92844
Kenneth Wen, M.D.	Pacific Cardiovascular Associates 681 S. Parker St., Suite 100	Orange	CA	92868
Safety Net				
Darya Amirshahrokhi	Pioneer Orthotics & Prosthetics 23672 Birtcher Dr., Unit A	Lake Forest	CA	92630
Pat Patton	UCI 101 The City Drive South	Orange	CA	92868
Leonardo Perez	Quantum Consulting and Professional Services 12430 Viarna St.	Cerritos	CA	90703
Alexander Rossel	Families Together OC 4 Giotto	Aliso Viejo	CA	92656

Board of Directors Meeting
June 4, 2020

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
Member Advisory Committee Update

At the April 23, 2020 OneCare Connect Member Advisory Committee (OCC MAC) meeting, Michael Schrader, Chief Executive Officer, introduced Richard Sanchez as the new Interim Chief Executive Officer and said farewell to the OCC MAC members and expressed his gratitude for all the collaboration he received from the committee.

Ladan Khamseh, Chief Operating Officer, updated the OCC MAC on the Qualified Medicare Beneficiary (QMB) Program and provided an overview of the QMB program that allows members to receive assistance from the State to pay their Medicare premiums. She also noted that outreach to members by CalOptima's customer service representatives has been undertaken to make sure they are well and to assist with any questions they may have about the Coronavirus (COVID-19).

David Ramirez, M.D., Chief Medical Officer, noted that the California Advancing and Innovating Medi-Cal (CalAIM) and the Pharmacy Carve out implementations had been postponed to allow the various managed care plans to effectively address COVID-19 throughout California.

OCC MAC received updates on COVID-19 by Miles Masatsugu, M.D., Medical Director, a Trauma Informed Care and Adverse Childhood Experiences Screen presentation by Betsy Ha, Executive Director, Quality and Population Health Management, a Federal and State Legislative Update by TC Roady, Director, Regulatory Affairs, and a Cultural and Linguistics update by Carlos Soto, Manager, Cultural and Linguistics.

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
June 4, 2020

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

April 28, 2020 WCM FAC Meeting

The members of the WCM FAC welcomed Richard Sanchez, Interim Chief Executive Officer, (CEO) and asked Mr. Sanchez to relay to Michael Schrader, outgoing CEO, their appreciation for all the support they were given during the transition from California Children's Services to CalOptima.

Jonathan T. Megerian, M.D., a board-certified pediatric neurologist at Children's Hospital of Orange County (CHOC), presented on CHOC's new Thompson Autism Center. This presentation solicited many questions from WCM FAC members as Dr. Megerian described the benefits and services that are available at this state-of-the-art center.

Along with a Chief Operating Officer (COO) report and a Chief Medical Officer (CMO) report, the members also received updates on the Coronavirus (COVID-19), a Federal and State Legislative update and a Cultural and Linguistics update.

The WCM FAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the WCM FAC's current activities. The next meeting is scheduled for June 23, 2020.

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Board of Directors Meeting
June 4, 2020

Provider Advisory Committee (PAC) Update

May 14, 2020 PAC Meeting

At the May 14, 2020 Provider Advisory Committee (PAC) meeting, the members approved their 2020-21 Meeting Schedule and considered and approved their recommendation of the slate of candidates that were presented by the PAC Nominations Ad Hoc Committee.

Richard Sanchez, Interim Chief Executive Officer, provided an update to PAC members and discussed Governor Newsom's May Revise to the proposed FY2020-21 California state budget. He also noted that the CalOptima Board of Directors would be reseated and Board members would be appointed on June 2, 2020. Mr. Sanchez notified that PAC that Dr. Clayton Chau has been selected and already started as the Director of the Orange County Health Care Agency. He also noted that CalOptima has formed an infection control partnership with the University of California, Irvine Medical Center to work with Skilled Nursing Facilities throughout Orange County.

Ladan Khamseh, Chief Operating Officer, thanked the providers and networks for working with CalOptima to ensure that members are getting access to the care that they need. She noted that CalOptima is continuing to provide information through the Provider Alerts, fax blasts and communications through CalOptima's website daily. She also noted that CalOptima Customer Service Representatives have been outreaching to members and advising them on what services are available through telehealth and how these services can be accessed.

PAC received an informational presentation on CalOptima's Virtual Care Strategy and Road Map to Increase Access to Care by both Betsy Ha, Executive Director, Quality and Population Health Management, and CalOptima consultant Sajid Ahmed of WISE Healthcare.

In addition, Chief Medical Officer David Ramirez, M.D., presented a COVID-19 update which elicited many questions from the PAC members. Also, TC Roady, Director of Regulatory Affairs, provided the PAC with a Federal and State Legislative update.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the PAC's activities.

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Board of Directors Meeting
June 4, 2020

Member Advisory Committee Update

May 14, 2020 MAC Meeting

At the May 14, 2020 Member Advisory Committee (MAC) meeting, the members approved their 2020-21 meeting schedule and approved the recommended slate of candidates that were presented by the MAC Nominations Ad Hoc Committee.

Richard Sanchez, Interim Chief Executive Officer, provided an update to MAC members and discussed Governor Newsom's May Revision to the California Budget and mentioned that CalOptima staff will be asking the Board to approve the FY2020-21 budget at the Board's June 4, 2020 meeting. He also noted that the CalOptima Board of Directors would be reseated and Board members would be selected by the Board of Supervisors on June 2, 2020. He also noted that, in partnership with the Orange County Health Care Agency, CalOptima is supporting a University of California, Irvine Medical Center program that works with Skilled Nursing Facilities throughout Orange County. On CalOptima's end, this innovative initiative is being led by Emily Fonda, M.D., Deputy Chief Medical Officer.

Dr. Fonda presented a COVID-19 update which elicited many questions from the MAC members.

MAC also received an informational update on CalOptima's Virtual Care Strategy and Road Map to Increase Access to Care from Betsy Ha, Executive Director, Quality and Population Health Management, and CalOptima virtual care consultant Sajid Ahmed of WISE Healthcare.

In addition to a COO update from Ladan Khamseh, TC Roady, Director of Regulatory 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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Impact of COVID-19 on Quality and Vulnerable Population

Board of Directors
June 4, 2020

Betsy Chang Ha, RN, MS, LSSMBB
Executive Director, Quality and Population Health Management

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Agenda

- CMS, DHCS, NCQA Quality Reporting Impact
- Member and Provider Impact
- Population Health Impact
- Mental Health Implication

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Quality Reporting Impact: CMS Guidance

- Due to the impact of COVID-19 on provider offices, Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) have issued guidance related to quality reporting requirements for measurement year (MY) 2019
  - Suspended the requirement for Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results to be reported to CMS for MY 2019 performance
  - Impacts our OneCare program
  - CMS will Use prior year (2018) HEDIS and CAHPS scores to calculate STARS scores and payments

Quality Reporting Impact: CMS Guidance (cont.)

- Health Outcomes Survey has been delayed by CMS. Expected to field in the fall.
- Reporting of HEDIS and CAHPS results for MMP plans was suspended
- Awaiting guidance on impact to MMP Quality Withhold program based on 2019 performance.

Quality Reporting Impact: DHCS and Pay For Value (P4V)

- CalOptima will continue to compile MY 2019 HEDIS results for all lines of business. All rates will be fully audited.
- DHCS has issued guidance that holds the plan to the MPL for select measures only. (those measures that did not require chart review). Plans can use with the current or prior year rate (whichever is best) to report select measures.
- CalOptima is expected to retain our top-level plan rating of 4.0 for an additional year
- Do not expect any adverse impact on 2019 P4V scoring or payments

NCQA Accreditation Impact

- Suspending calculation of health plan ratings based on 2019 performance due to COVID-19
- Extending the grace period two months to allow 16 months for annual requirements, such as analysis, member communications and delegation oversight
- Extending practitioner and provider recredentialing cycle by two months to 38 months
- File review preparations in progress, lookback period begins May 2020
- No impact to file submission in preparation for NCQA onsite review scheduled May 21, 2021

COVID-19 Impact

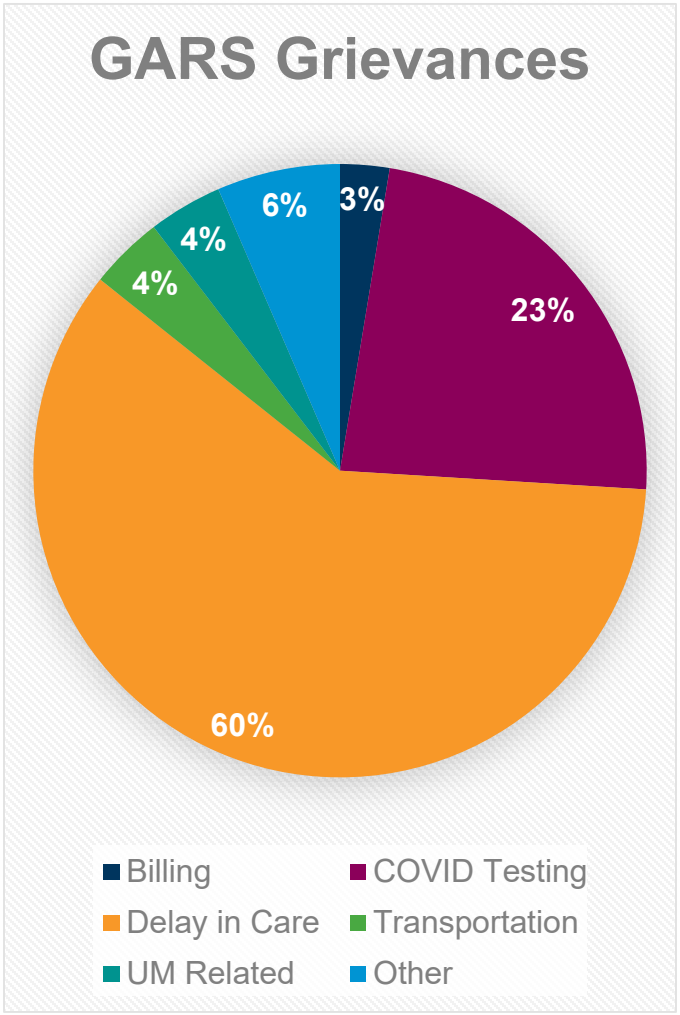
Member Experience

- Members cancelling appointments because they are afraid to go out
- Members requesting locations of testing sites
- Members asking about coverage for COVID-19
- Members complaining their providers do not have testing available
- Members complaining their providers won't see them due to outbreak of COVID-19
- Members inquiring about providers who do telehealth visits due to anxiety of going in person
- Members receive delay in care due to adjusted hours, rescheduled or cancelled appointments, e.g., not able to obtain durable medical equipment (DME), medications, not able to access provider, etc.

Provider Experience

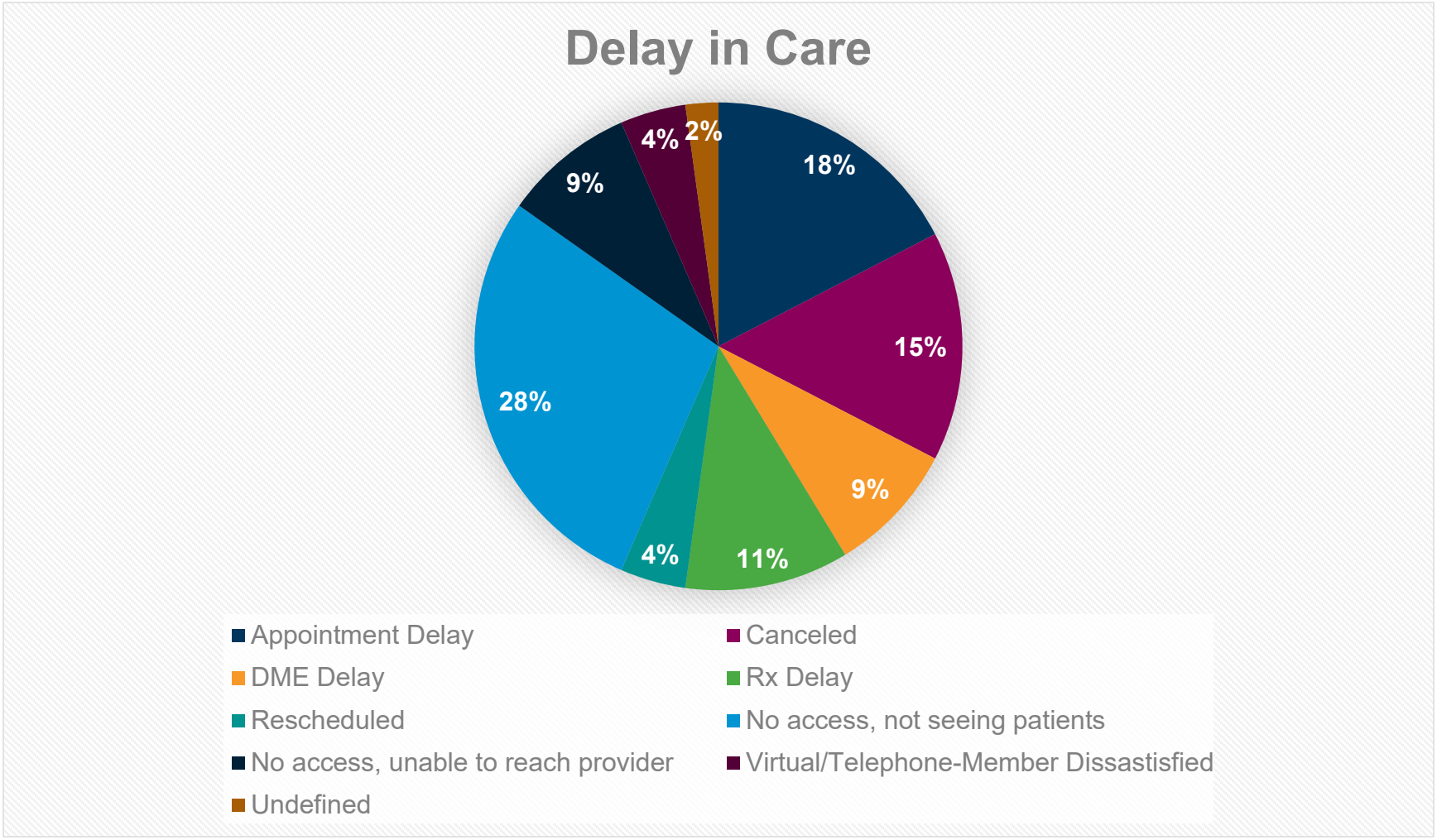
- Providers changing hours, consolidating services and sites
- Providers cancelling elective surgeries and procedures
- Providers changing to phone consultations/telehealth
- Providers unclear about testing sites and current testing strategy
- Providers new to Medi-Cal can emergency enroll through DHCS to see members at Medi-Cal rates
- Provider Facility Site Reviews temporarily on hold due to COVID-19, impacting credentialing and tri-annual FSR

Member Experience: GARS Grievances



Data Source: Member Grievances (March 1 through May 1, 2020) = 77

Member Experience: GARS Top Grievances by Sub-Category



Member Grievances sub-category (March 1 - May 1, 2020) = 46

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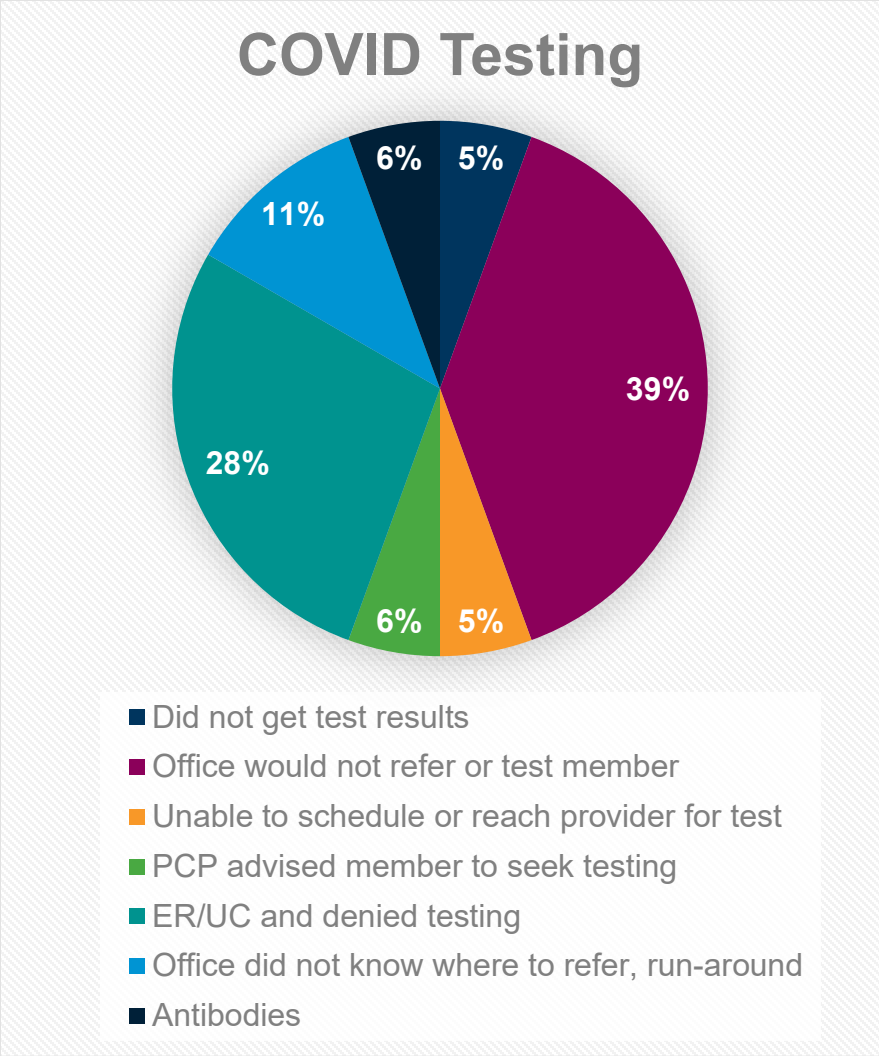
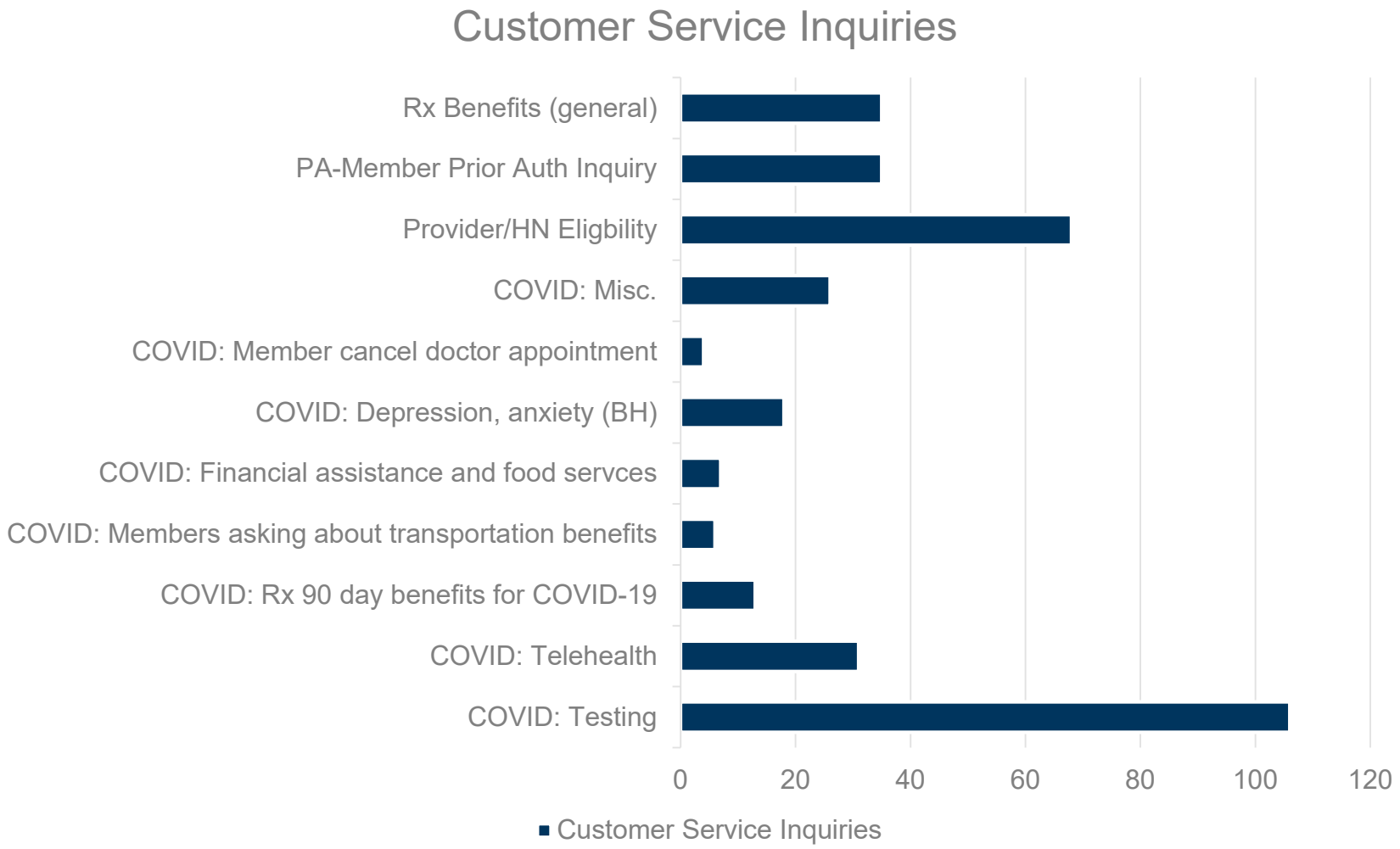
Member Experience: GARS Top Grievances by Sub-Category (cont.)



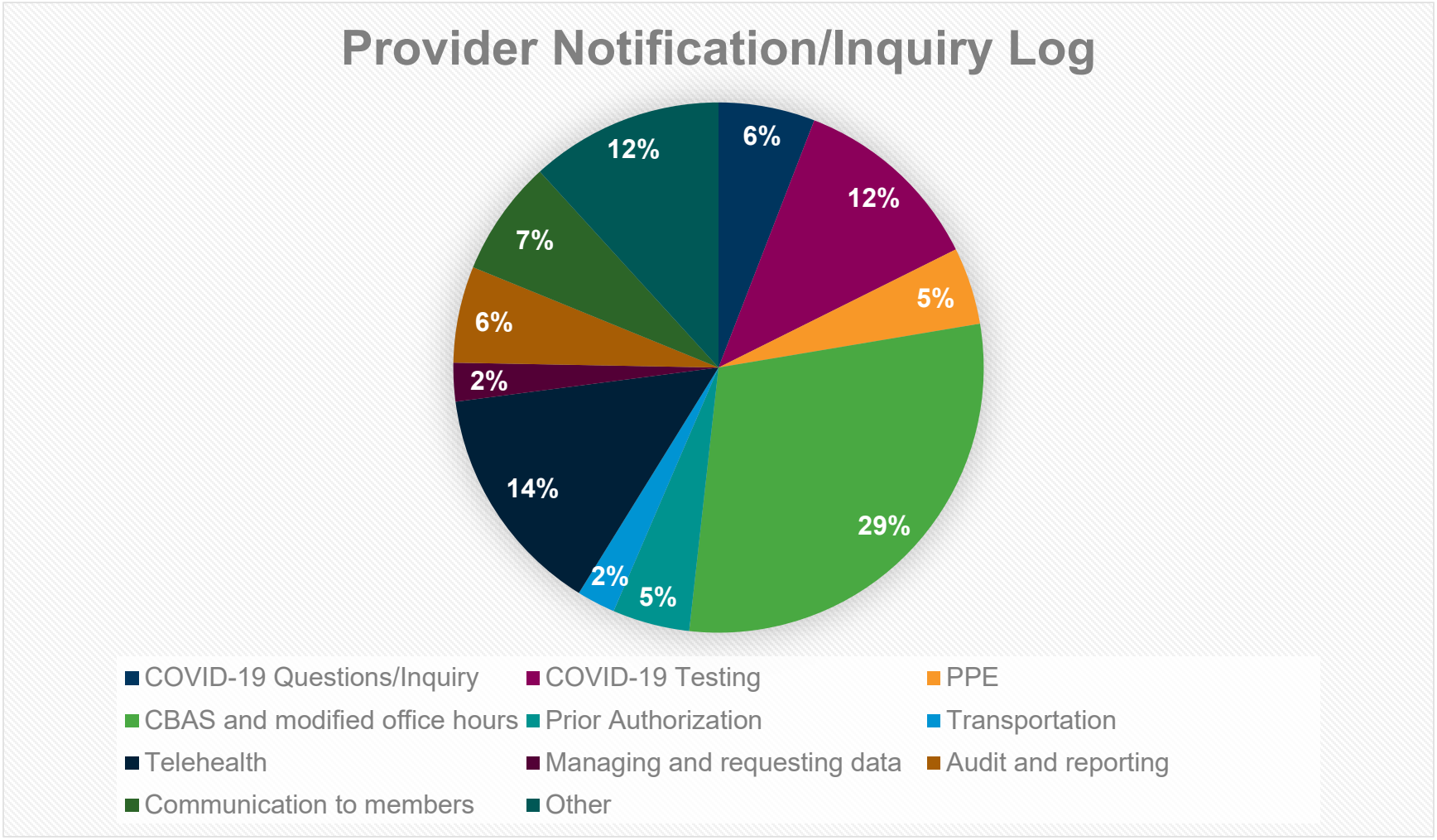
Member Grievances sub-category (March 1 - May 1, 2020) = 18

Member Experience: Customer Service Inquiries



Data Source: Customer Service Inquiries (March 1 - April 24, 2020) = 349

Provider Relations: Notification/Inquiry Log



Data source: Provider Relations Inquiry Log (March 1 - April 24, 2020) = 85

Population Health Management

- Outreach to emerging risk populations
  - Bright Steps Maternity Management Program
    - Including “You are Not Alone” First 5 OC Coronavirus pamphlet in CalOptima Bright Steps weekly mailings
    - Informing Bright Steps participants about changes to hospital labor and delivery protocols
    - Screen everyone who comes and goes, allow one additional person plus delivering mom in delivery room, and require wearing a mask, etc.
  - Chronic Conditions
    - Modified scripts for members with asthma, diabetes and COPD to educate COVID-19 prevention strategies and offering CalOptima assistance with medication refills, medical equipment or community resources
- General education
  - COVID-19 outreach and prevention awareness interactive voice response (IVR) campaign
  - COVID-19 educational videos on CalOptima website

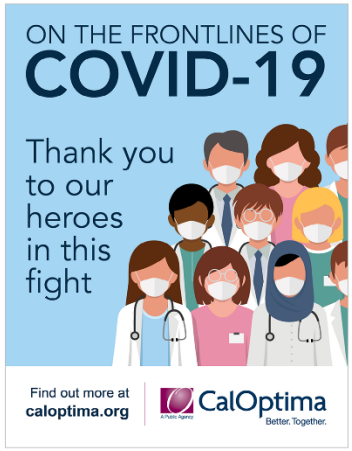
Population Health Management (cont.)

- COVID-19 Community Awareness Campaign

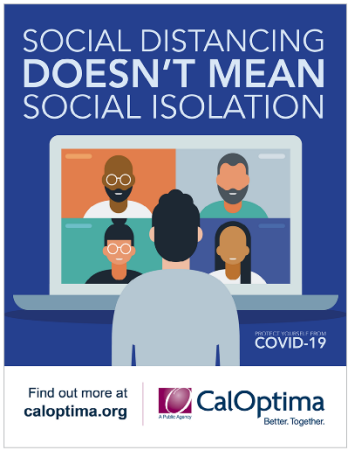












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Population Health Management (cont.)

- Public service announcements to support CalOptima vulnerable populations impacted by COVID-19
  - Taking Care of Your Emotional Health
  - Maternal Mental Health
  - Continuing Prenatal Care
  - Healthy Nutrition and Activity
  - Chronic condition management and support with medications
- Link to video spots

COVID-19, Adverse Childhood Experiences (ACEs) and Toxic Stress

"ACEs and toxic stress represent a public health crisis."

~Nadine Burke Harris, M.D.
California Surgeon General



Mental Health Implications

- DHCS All Plan Letter 20-008
  - Support continuity and integration of medical and behavioral health services via telehealth
  - Ensure strong care coordination and service linkage
  - Educate providers on disaster-responsive, trauma-informed care
  - Ensure providers learn the signs of and assess for stress-related morbidity and create responsive treatment plans

Member-Focused Activities

- Expand telehealth for Behavioral Health (BH)
- Identify BH providers who specialize in trauma-informed care and anxiety disorders
  - Post-traumatic stress disorder (PTSD)
  - Obsessive-compulsive disorder (OCD)
- Make licensed BH clinicians available in real time to assist members in mental health crisis
- Offer appointment assistance to members seeking mental health services
- Train all BH staff on ACEs and trauma-informed care
- Continue to promote BH phone line available 24/7 at 1-855-877-3885

Community-Focused Activities

- Collaborate with County Behavioral Health Services and Be Well OC to share mental health resources
  - https://coronavirus.egovoc.com/health-care-providers-first-responders
  - https://mental-wellness.bewelloc.org/
  - www.caloptima.org/en/Features/COVID-19/CommunityCommunication.aspx

- Educate community-based organizations on how to support members with mental health concerns due to COVID-19 health emergency


Crisis
危機
A time of danger
A time of opportunity
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Photo Courtesy of Betsy Ha

Questions?

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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Members Experiencing Homelessness Update

Board of Directors Meeting

June 4, 2020

David Ramirez, MD, Chief Medical Officer

Marie J. Jeannis, RN, MSN, Director (Interim) Enterprise Analytics

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Content Overview

- Goals
- CalOptima Homeless Population Clinical Report Card
- Homeless Enrollment Trends
- Homeless Utilization Trends
  - Primary Care Provider (PCP) Visit Trends
  - Specialist Visit Trends
  - Telehealth Service Trends
  - Inpatient (IP) Trends
  - Emergency Department (ED) Trends
- Disparities: Medical and Behavioral Health (BH) Diagnoses
- Coroner's Report Monthly Cases
- Summary

Goals

- Homeless population clinical analysis goals
  - Define and understand the population
  - Improve the quality and scope of data collection
  - Improve data integrity
  - Increase data sources
  - Assess current interventions
  - Identify opportunities for change or improvements

CalOptima Homeless Report Card

- CalOptima's Homeless Population Clinical Report Card is reported quarterly and monitors key performance measures for this vulnerable population
- Homeless Population Clinical Report Card trends:
  - Enrollment
  - Utilization metrics
  - Metrics for homeless initiatives
    - Clinical Field Team (CFT) Visits
    - Mobile Clinic Visits

CalOptima Homeless Population Clinical Report Card

Enrollment Per Year

From: 2015 To: 2020-02

	2015	2016	2017	2018	2019	2020 YTD
Total Homeless Members	6,843	7,670	9,142	10,910	11,585	11,351
Enrolled in Whole Person Care			3,612	5,078	5,244	4,756
Enrolled in Health Homes Progam						258

Telehealth Services

Last 12 months by Quarters

	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2
Telehealth Visit Ct	0	0	2	95	73

Clinical Field Team (CFT) Visits

From: 2019-04 To: 2020-03 (3/31/20)

	2019 Q2	2019 Q3	2019 Q4	2020 Q1	Total
# Calls Dispatched	96	183	226	167	672
% Treated	100%	100%	100%	100%	100%
% CalOptima Members (Treated)	92%	83%	88%	92%	88%
% Recuperative Care Referrals (Treated)	8%	19%	20%	20%	17%

CFT Mobile Clinic Visits

From: 2019-04 To: 2019-12

Place Of Service	Q2 2019	Q3 2019	Q4 2019	Total
Homeless Shelter	1		6	7
Mobile Unit	6	7	2	15
Temporary Housing		5	5	10
Other Unlisted Facility	0	12	11	24
Grand Total	7	25	25	56

Utilization Metrics

From: 2015-01 To: 2019-12

PCP and Specialist Visit Rates

	2015	2016	2017	2018	2019
Number of PCP Visits	10,073	9,990	13,287	16,111	16,617
PCP Visits Per Member	1.5	1.3	1.5	1.5	1.4
% With PCP Visit	30%	28%	30%	33%	36%
Number of Specialist Visits	12,706	15,872	25,540	34,432	38,382
Spec Visits Per Member	1.9	2.1	2.8	3.2	3.3

Inpatient Metrics

	2015	2016	2017	2018	2019
Admits	1,736	2,207	3,553	4,656	5,173
Admits PTMPY	254	288	389	427	446
Bed Days	8,547	9,362	17,111	22,965	28,191
Bed Days PTMPY	1,249	1,221	1,871	2,105	2,433
% Readmit	20%	23%	26%	28%	31%

Emergency Department Rates

	2015	2016	2017	2018	2019
ED Visits	10,785	12,761	18,411	23,041	26,602
ED Visits PTMPY	1,576	1,664	2,014	2,112	2,297

Workbook: Quarterly QIC Reporting Tableau Workbook_Final Report Date: 5/12/2020

Source: CalOptima data

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Homeless Enrollment Trends

- Number of homeless Medi-Cal members has increased significantly, especially after the start of the Whole Person Care (WPC) Program
  - WPC enrollment began in 2017
  - Heath Homes program began in 2020

Enrollment Per Year

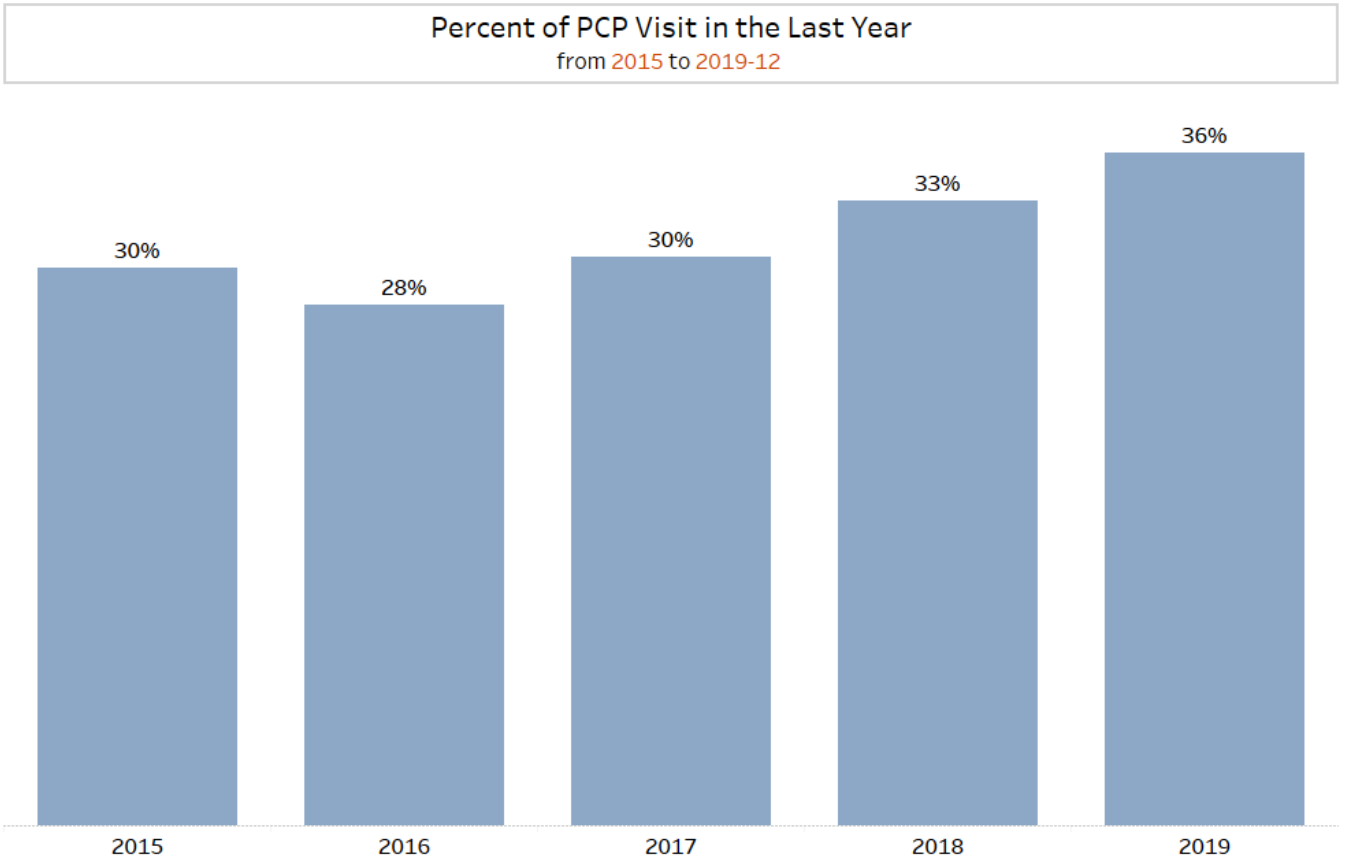
From: 2015 To: 2020-02

	2015	2016	2017	2018	2019	2020 YTD
Total Homeless Members	6,843	7,670	9,142	10,910	11,585	11,351
Enrolled in Whole Person Care			3,612	5,078	5,244	4,756
Enrolled in Health Homes Progam						258

Source: CalOptima data

Primary Care Provider Visit Trends

- Percent of homeless members with at least one annual PCP visit has been increasing



Source: CalOptima data

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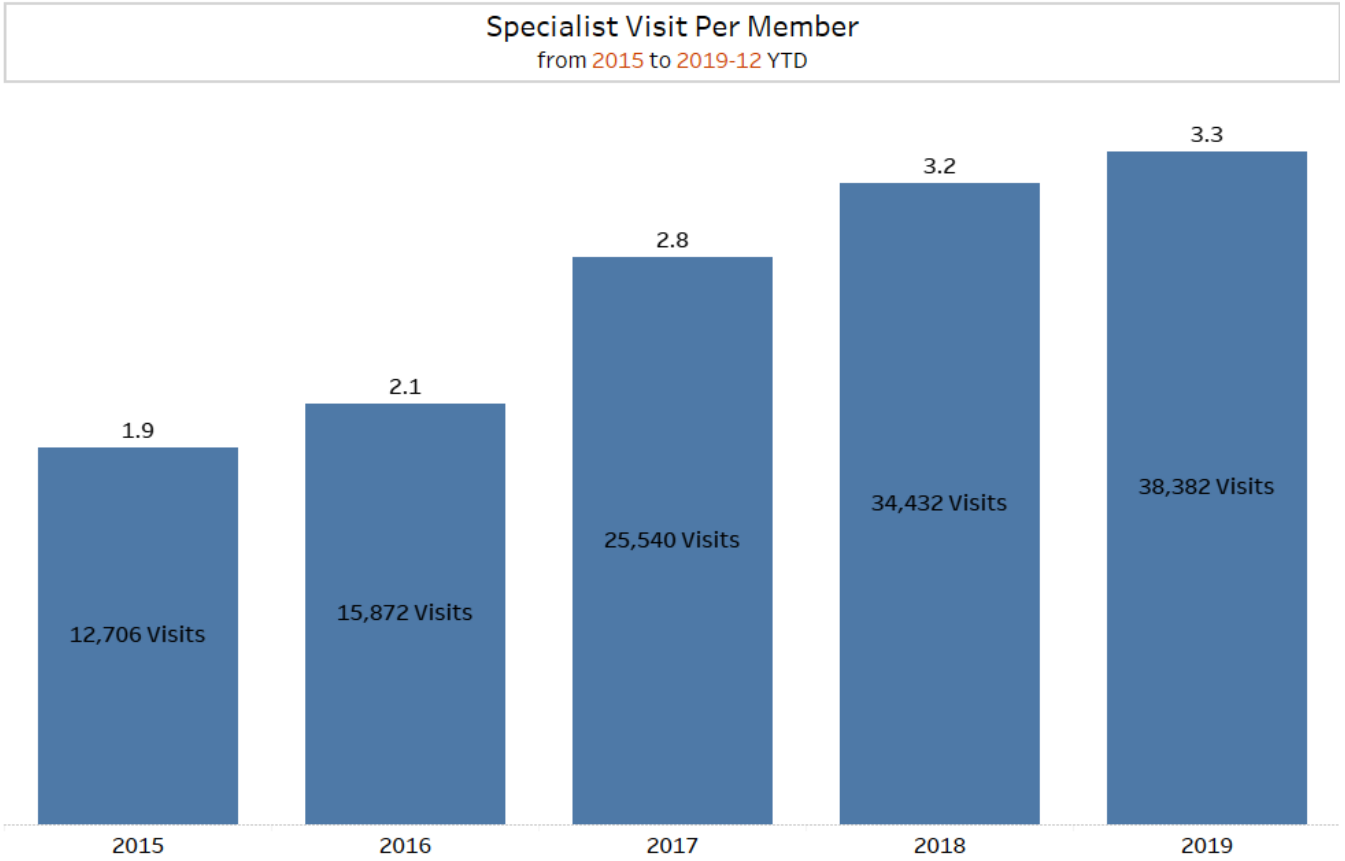
Specialist Visit Trends

- Rate of specialist visits has increased
  - Most significantly after 2017



Source: CalOptima data

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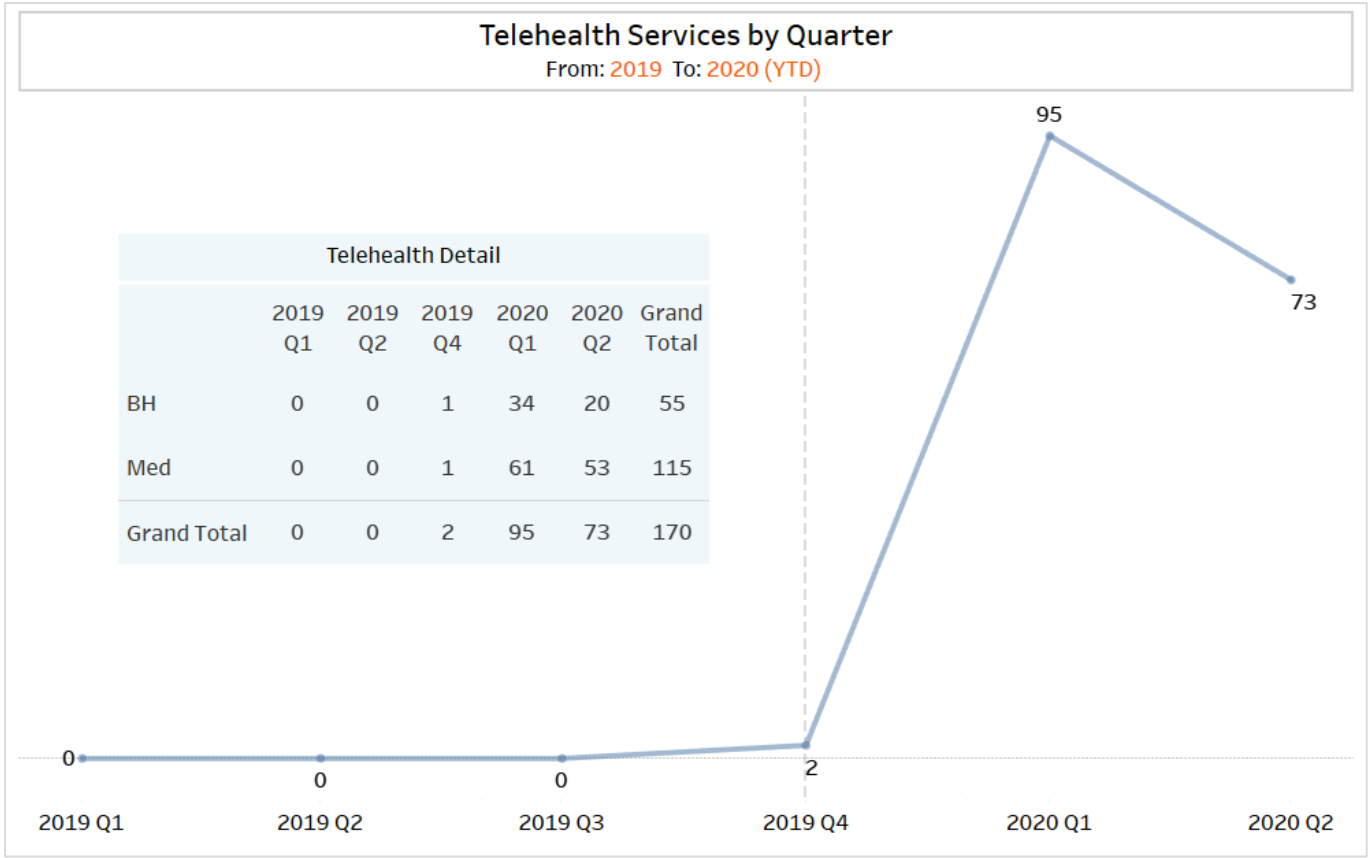
Telehealth Service Trends

- Telehealth services increased substantially
  - To support social distancing implemented during the COVID-19 pandemic
  - First case Jan 2020
  - Declared a global pandemic March 2020



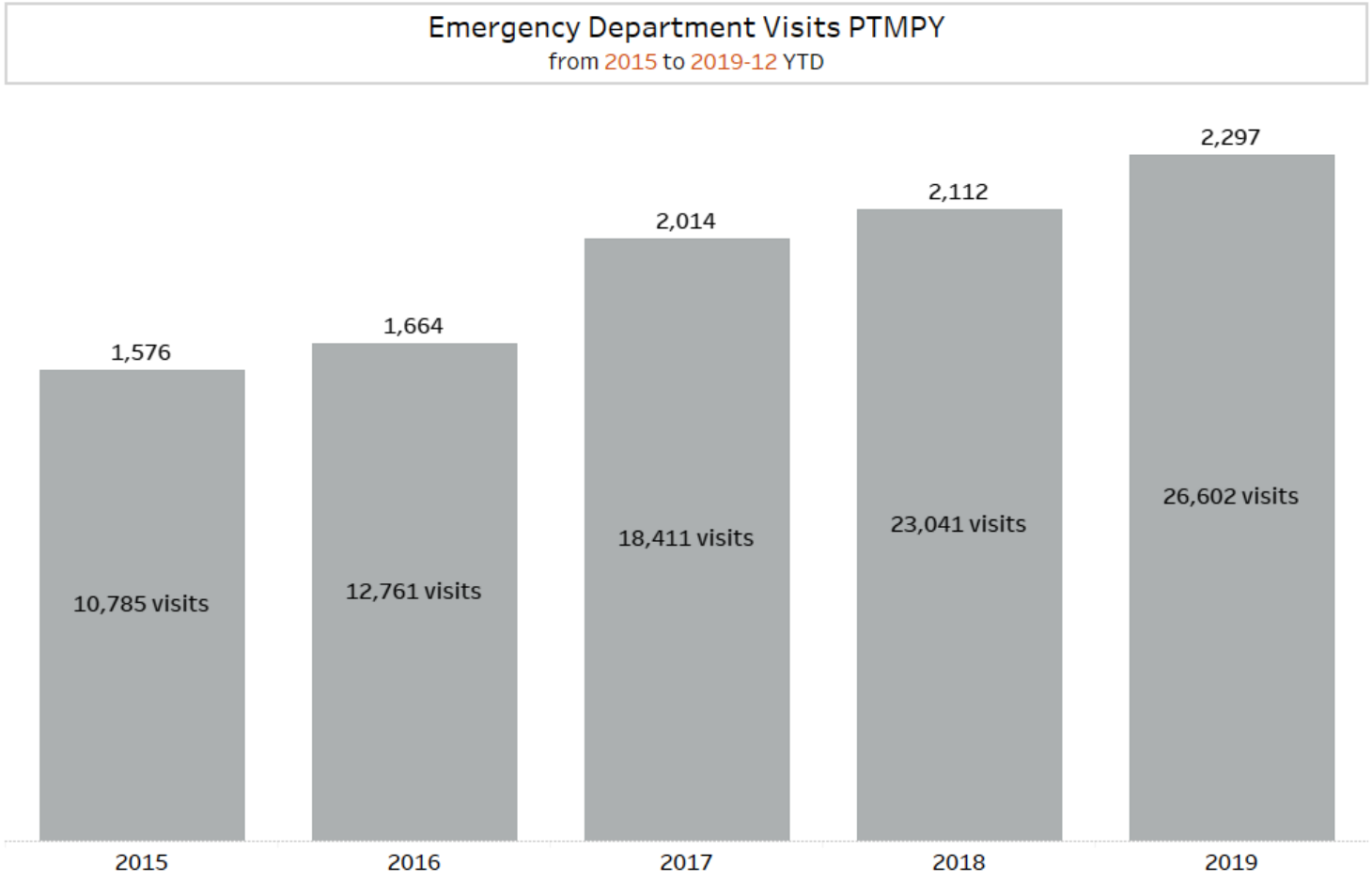
Telehealth Detail

	2019 Q1	2019 Q2	2019 Q4	2020 Q1	2020 Q2	Grand Total
BH	0	0	1	34	20	55
Med	0	0	1	61	53	115
Grand Total	0	0	2	95	73	170

Source: CalOptima data

Emergency Department Trends

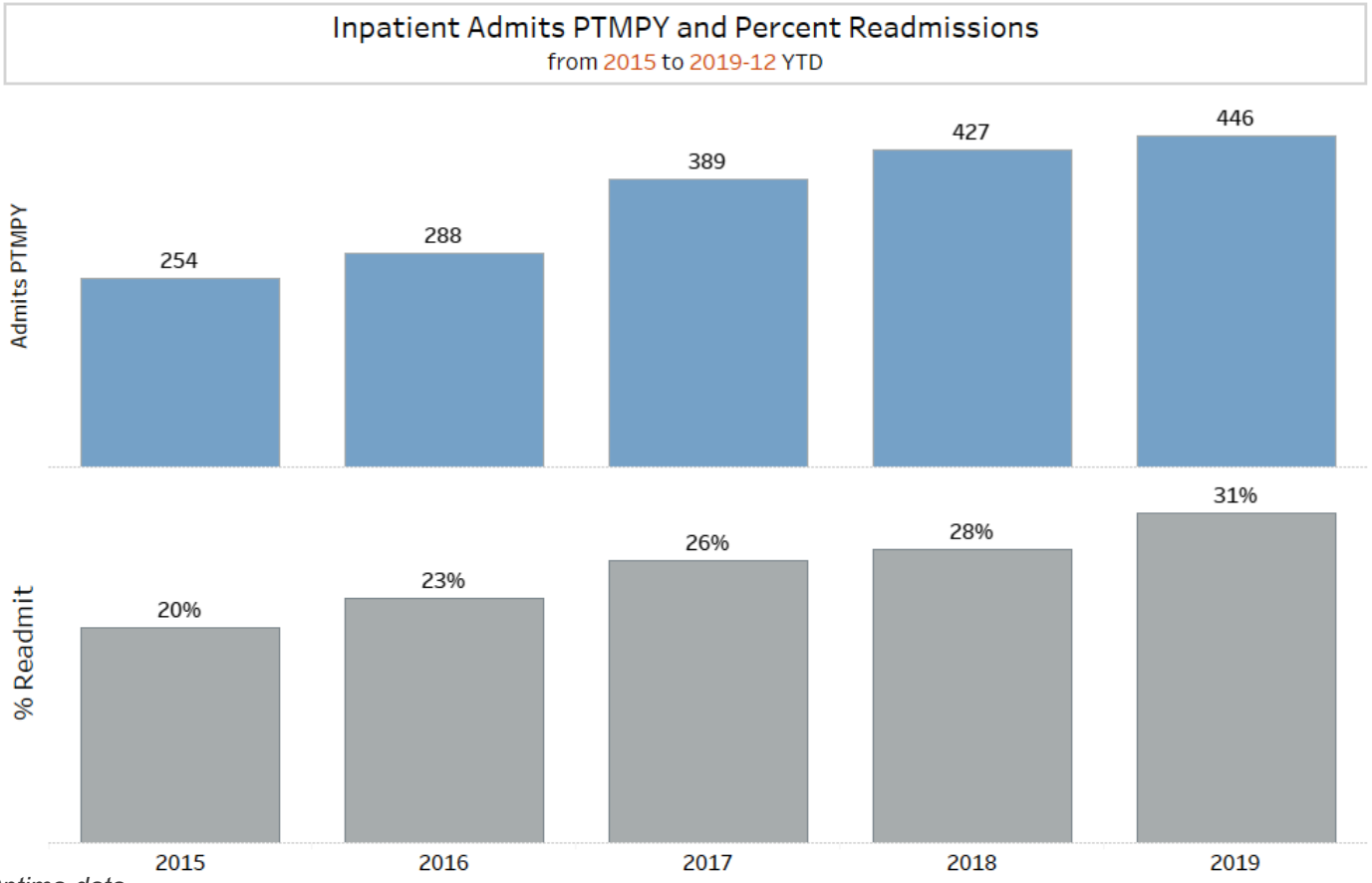
- ED visit rates have increased



Source: CalOptima data

Inpatient Trends

- Admits per member have increased
  - ➢ Percent readmissions continues to rise



Source: CalOptima data

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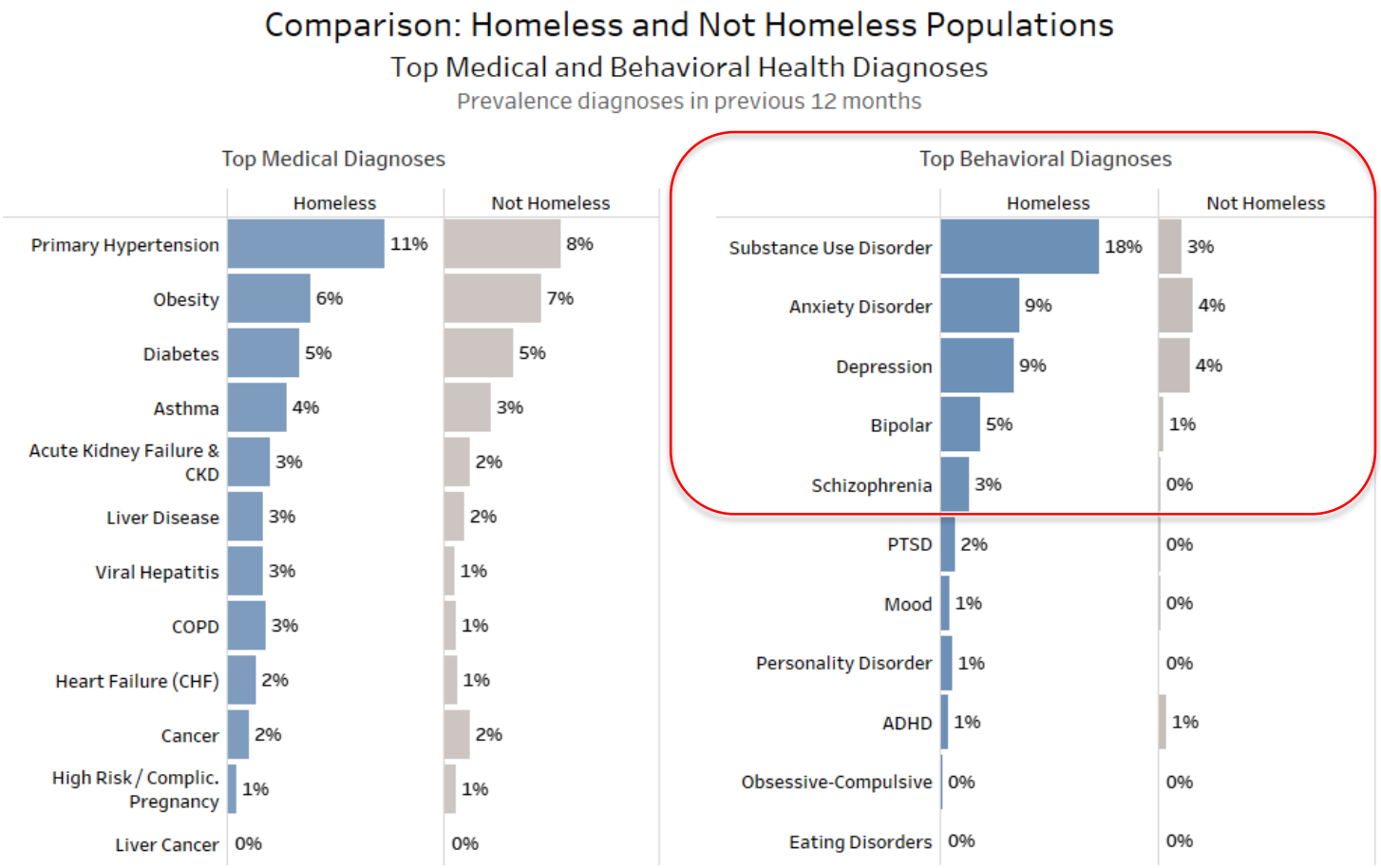
Disparities: Medical and BH Diagnoses



- Medical diagnoses are not significantly different in homeless and not homeless
- BH diagnoses for homeless range from two to six times higher than not homeless

Source: CalOptima data

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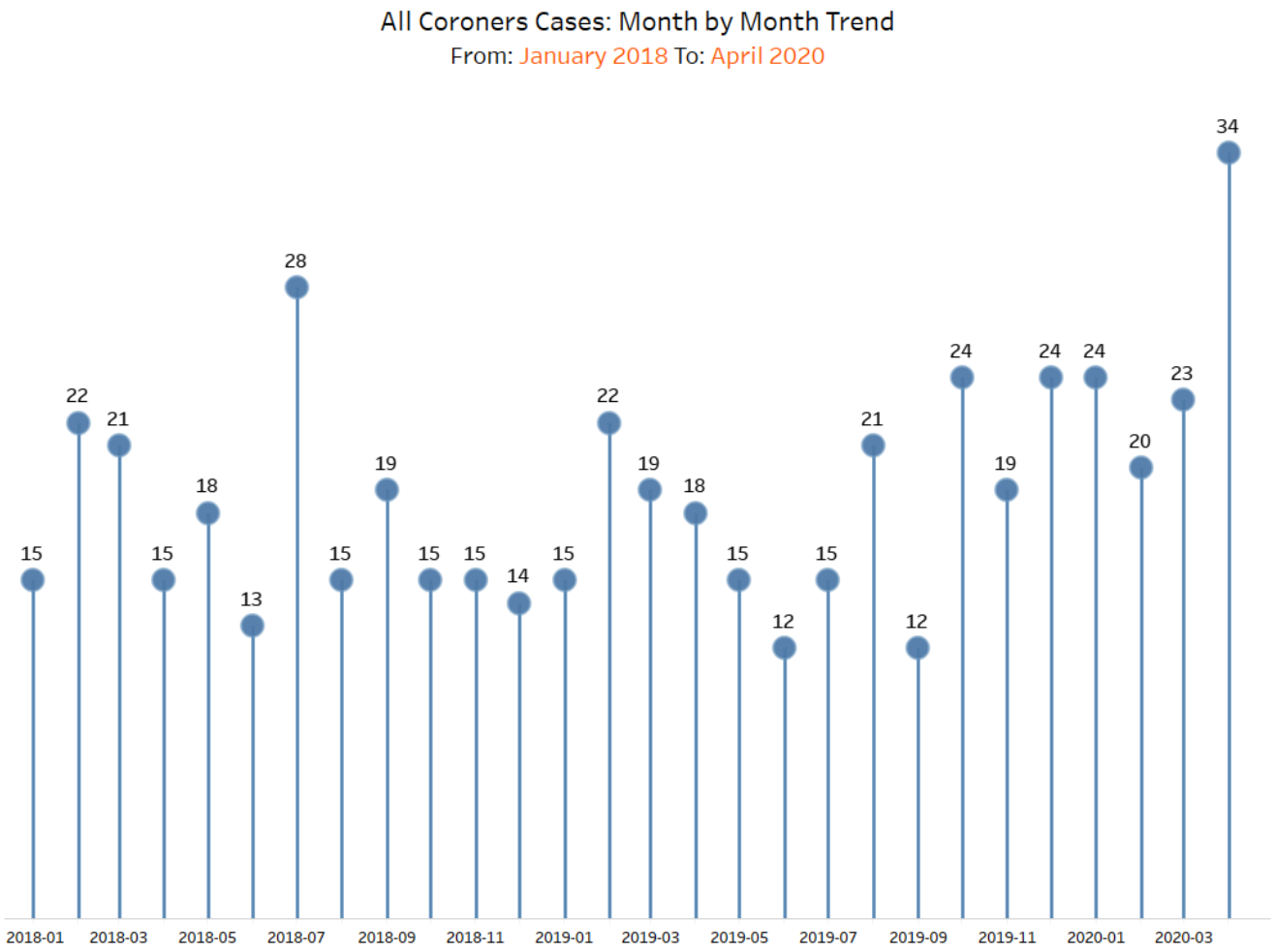
Summary: 2015–2019

- The number of members who are experiencing homelessness has continued to increase year over year, although at a slower rate
- Members experiencing homelessness utilize significant amounts of health care services through CalOptima
- Increase in annual PCP visit rates, specialist, emergency department, and inpatient utilization
  - Current interventions including WPC support increased member engagement with the health care system
- BH and substance abuse conditions are significantly more common in the homeless population
  - Substance abuse appears to be a factor in the majority of deaths

Coroner's Report Monthly Cases

- Overall 50%–65% of reported coroner cases were CalOptima members
  - COVID-19 reported as contributing cause of death for 1 CalOptima member in March
  - 22 of 34 were members in April
- 48% increase in reported cases from March to April
  - Mode of death still pending for more than 60% of April cases
  - Reported modes not different than typical



Source: Coroner's Report

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Summary: 2020

- Orange County has substantially increased shelter beds and locations
  - County is providing COVID-19 testing and tracking results
  - Individuals with symptoms or positive tests are isolated to prevent spread
- CalOptima Board approved expansion of Homeless Clinical Access Program (HCAP) incentives to include CFT services and telehealth visits
  - CFT's continue to be available 6 days and 48 hours per week
- Utilization of telehealth services has increased measurably due to COVID-19 pandemic and social distancing
- Coroner's case reporting frequency has been increased to weekly (from monthly) to facilitate identification of trends

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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Financial Summary

April 2020

Board of Directors Meeting

June 4, 2020

Nancy Huang

Chief Financial Officer

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FY 2019-20: Consolidated Enrollment

April 2020 MTD

Overall enrollment was 737,154 members

- Actual lower than budget 446 or 0.1%
  - Medi-Cal unfavorable to budget 579 or 0.1%
    - Medi-Cal Expansion (MCE) unfavorable variance of 7,366
    - Whole Child Model (WCM) unfavorable variance of 1,910
    - Temporary Assistance for Needy Families (TANF) favorable variance of 6,739
    - Seniors and Persons with Disabilities (SPD) favorable variance of 1,804
    - Long-Term Care (LTC) favorable variance of 154
  - OneCare Connect favorable to budget 293 or 2.1%
  - OneCare unfavorable to budget 151 or 10.0%
  - PACE unfavorable to budget 9 or 2.2%
- 8,005 increase or 1.1% from March
    - Medi-Cal increase of 7,928
    - OneCare Connect increase of 74
    - OneCare no change
    - PACE increase of 3

FY 2019-20: Consolidated Enrollment (cont.)

April 2020 YTD

Overall enrollment was 7,376,625 member months

- Actual lower than budget 74,916 or 1.0%
  - Medi-Cal unfavorable to budget 75,684 or 1.0%
    - MCE unfavorable variance of 75,960
    - WCM unfavorable variance of 14,837
    - SPD favorable variance of 11,943
    - TANF favorable variance 2,309
    - LTC favorable variance of 860
  - OneCare Connect favorable to budget 1,100 or 0.8%
  - OneCare unfavorable to budget 348 or 2.3%
  - PACE favorable to budget 16 or 0.4%

FY 2019-20: Consolidated Revenues

April 2020 MTD

- Actual higher than budget $4.2 million or 1.4%
  - ➢ Medi-Cal unfavorable to budget $2.6 million or 1.0%
    - Unfavorable volume variance of $0.2 million
    - Unfavorable price variance of $2.4 million
      - $6.7 million of LTC revenue from non-LTC categories of aid
      - $6.0 million of Coordinated Care Initiative (CCI) revenue
      - $3.6 million of Behavioral Health Treatment (BHT) revenue
      - Offset by $13.8 million of revenue from initial estimates of May Revise impact and updated rates from the Department of Health Care Services (DHCS)
      - $3.3 million of WCM revenue

FY 2019-20: Consolidated Revenues (cont.)

April 2020 MTD (cont.)

- OneCare Connect favorable to budget $11.8 million or 49.3%
  - Favorable volume variance of $0.5 million
  - Favorable price variance of $11.3 million
    - $6.8 million from calendar year (CY) 2019 Hierarchical Condition Category (HCC) reconciliation
    - $3.7 million of CY 2015 through 2018 estimated Centers for Medicare & Medicaid Services (CMS) HCC records adjustment
- OneCare unfavorable to budget $5.2 million or 315.0%
  - Unfavorable volume variance of $0.2 million
  - Unfavorable price variance of $5.0 million due to CY 2015 through 2018 estimated CMS HCC records adjustment
- PACE favorable to budget $254.3 thousand or 8.0%
  - Unfavorable volume variance of $69.7 thousand
  - Favorable price variance of $324.0 thousand

FY 2019-20: Consolidated Revenues (cont.)

April 2020 YTD

- Actual higher than budget $255.7 million or 8.6%
  - ➢ Medi-Cal favorable to budget $239.8 million or 8.9%
    - Unfavorable volume variance of $27.9 million
    - Favorable price variance of $267.7 million
      - $195.3 million of Directed Payments (DP) revenue
      - $74.5 million of CCI revenue due to updated rate and member mix
      - $23.8 million of LTC revenue from non-LTC categories of aid
      - $18.2 million of BHT revenue
      - Offset by $13.8 million of revenue from initial estimates of May Revise impact and updated rates from DHCS
      - $36.4 million of WCM revenue

FY 2019-20: Consolidated Revenues (cont.)

April 2020 YTD (cont.)

- OneCare Connect favorable to budget $18.9 million or 7.9%
  - Favorable volume variance of $1.9 million
  - Favorable price variance of $17.0 million
    - $6.8 million from CY 2019 HCC reconciliation
    - $6.4 million of Part D revenue
    - $3.7 million of CY 2015 through 2018 estimated CMS HCC records adjustment
- OneCare unfavorable to budget $4.5 million or 27.7%
  - Unfavorable volume variance of $0.4 million
  - Unfavorable price variance of $4.2 million due to CY 2015 through 2018 estimated CMS HCC records adjustment
- PACE favorable to budget $1.6 million or 5.3%
  - Favorable volume variance of $0.1 million
  - Favorable price variance of $1.4 million

FY 2019-20: Consolidated Medical Expenses

April 2020 MTD

- Actual higher than budget $7.7 million or 2.7%
  - ➢ Medi-Cal unfavorable variance of $1.3 million or 0.5%
    - Favorable volume variance of $0.2 million
    - Unfavorable price variance of $1.5 million
      - Prescription Drugs unfavorable variance of $7.5 million due to increased utilization
      - Professional Claims unfavorable variance of $3.4 million due to crossover claims
      - Provider Capitation unfavorable variance of $1.8 million
      - Facilities Claims favorable variance of $8.6 million
      - Medical Management favorable variance of $1.9 million
      - Reinsurance & Other favorable variance of $1.8 million
  - ➢ OneCare Connect unfavorable variance of $8.7 million or 37.6%
    - Unfavorable volume variance of $0.5 million
    - Unfavorable price variance of $8.2 million

FY 2019-20: Consolidated Medical Expenses (cont.)

April 2020 YTD

- Actual higher than budget $265.7 million or 9.4%
  - ➢ Medi-Cal unfavorable variance of $256.1 million or 10.0%
    - Favorable volume variance of $26.5 million
    - Unfavorable price variance of $282.6 million
      - Reinsurance and Other unfavorable variance of $181.1 million due to $195.5 million of DP, offset by favorable variance in Homeless Health Initiative
      - Professional Claims unfavorable variance of $36.6 million
      - Facilities Claims unfavorable variance of $32.9 million
      - Prescription Drugs unfavorable variance of $22.9 million
  - ➢ OneCare Connect unfavorable variance of $13.3 million or 5.7%
    - Unfavorable volume variance of $1.8 million
    - Unfavorable price variance of $11.4 million

Medical Loss Ratio (MLR)

- April 2020 MTD: Actual: 96.3% Budget: 95.1%
- April 2020 YTD: Actual: 95.9% Budget: 95.2%

FY 2019-20: Consolidated Administrative Expenses

April 2020 MTD

- Actual lower than budget $1.3 million or 9.1%
  - Salaries, wages and benefits: favorable variance of $0.7 million
  - Other categories: favorable variance of $0.6 million

April 2020 YTD

- Actual lower than budget $17.3 million or 13.2%
  - Salaries, wages and benefits: favorable variance of $7.5 million
  - Other categories: favorable variance of $9.8 million

Administrative Loss Ratio (ALR)

- April 2020 MTD: Actual: 4.2% Budget: 4.7%
- April 2020 YTD: Actual: 3.5% Budget: 4.4%
  - Actual ALR (excluding DP revenue) is 3.7% YTD

FY 2019-20: Change in Net Assets

April 2020 MTD

- $6.3 million change in net assets
- $4.3 million favorable to budget
  - Higher than budgeted revenue of $4.2 million
  - Higher than budgeted medical expenses of $7.7 million
  - Lower than budgeted administrative expenses of $1.3 million
  - Higher than budgeted investment and other income of $6.5 million

April 2020 YTD

- $54.6 million change in net assets
- $29.9 million favorable to budget
  - Higher than budgeted revenue of $255.7 million
  - Higher than budgeted medical expenses of $265.7 million
  - Lower than budgeted administrative expenses of $17.3 million
  - Higher than budgeted investment and other income of $22.6 million

Enrollment Summary: April 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
66,772	66,372	400	0.6%	Aged	659,753	657,802	1,951	0.3%
513	615	(102)	(16.6%)	BCCTP	5,286	6,150	(864)	(14.0%)
45,058	43,552	1,506	3.5%	Disabled	447,946	437,090	10,856	2.5%
280,927	275,292	5,635	2.0%	TANF Child	2,817,557	2,814,109	3,448	0.1%
84,912	83,808	1,104	1.3%	TANF Adult	858,287	859,426	(1,139)	(0.1%)
3,558	3,404	154	4.5%	LTC	34,900	34,040	860	2.5%
228,466	235,832	(7,366)	(3.1%)	MCE	2,278,413	2,354,373	(75,960)	(3.2%)
11,030	12,940	(1,910)	(14.8%)	WCM	114,563	129,400	(14,837)	(11.5%)
721,236	**721,815**	**(579)**	**(0.1%)**	**Medi-Cal Total**	**7,216,706**	**7,292,390**	**(75,684)**	**(1.0%)**
14,151	**13,858**	**293**	**2.1%**	**OneCare Connect**	**141,458**	**140,358**	**1,100**	**0.8%**
1,364	**1,515**	**(151)**	**(10.0%)**	**OneCare**	**14,696**	**15,044**	**(348)**	**(2.3%)**
403	**412**	**(9)**	**(2.2%)**	**PACE**	**3,765**	**3,749**	**16**	**0.4%**
737,154	**737,600**	**(446)**	**(0.1%)**	**CalOptima Total**	**7,376,625**	**7,451,541**	**(74,916)**	**(1.0%)**

Financial Highlights: April 2020

CalOptima - Consolidated
Financial Highlights
For the Ten Months Ended April 30, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
737,154	737,600	(446)	(0.1%)	Member Months	7,376,625	7,451,541	(74,916)	(1.0%)
301,259,840	297,010,806	4,249,034	1.4%	Revenues	3,227,995,029	2,972,293,296	255,701,732	8.6%
290,074,117	282,377,707	(7,696,411)	(2.7%)	Medical Expenses	3,094,989,393	2,829,269,272	(265,720,120)	(9.4%)
12,670,370	13,941,118	1,270,748	9.1%	Administrative Expenses	113,464,673	130,794,020	17,329,347	13.2%
(1,484,647)	**691,982**	**(2,176,629)**	**(314.6%)**	**Operating Margin**	**19,540,963**	**12,230,004**	**7,310,959**	**59.8%**
7,773,077	1,250,000	6,523,077	521.8%	Non Operating Income (Loss)	35,107,869	12,500,000	22,607,869	180.9%
6,288,430	**1,941,982**	**4,346,448**	**223.8%**	**Change in Net Assets**	**54,648,832**	**24,730,004**	**29,918,828**	**121.0%**
96.3%	95.1%	(1.2%)		Medical Loss Ratio	95.9%	95.2%	(0.7%)	
4.2%	4.7%	0.5%		Administrative Loss Ratio	3.5%	4.4%	0.9%	
(0.5%)	0.2%	(0.7%)		Operating Margin Ratio	0.6%	0.4%	0.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
				*Administrative Loss Ratio (excluding Directed Payments)	3.7%			

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

Consolidated Performance Actual vs. Budget: April 2020 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(1.3)	1.6	(2.9)	Medi-Cal	22.5	24.0	(1.5)
2.2	(1.0)	3.2	OCC	(4.6)	(12.6)	8.0
(3.0)	(0.1)	(2.9)	OneCare	(2.6)	(1.1)	(1.5)
0.6	0.3	0.3	PACE	4.2	1.9	2.3
(1.5)	**0.7**	**(2.2)**	**Operating**	**19.5**	**12.2**	**7.3**
7.8	1.3	6.5	Inv./Rental Inc, MCO tax	35.1	12.5	22.6
7.8	**1.3**	**6.5**	**Non-Operating**	**35.1**	**12.5**	**22.6**
6.3	**1.9**	**4.3**	**TOTAL**	**54.6**	**24.7**	**29.9**

Consolidated Revenue & Expense: April 2020 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	481,740	228,466	11,030	721,236	14,151	1,364	403	737,154
REVENUES								
Capitation Revenue	152,121,770	$ 94,861,772	$ 18,611,775	$ 265,595,317	$ 35,743,859	$ (3,523,694)	$ 3,444,359	$ 301,259,840
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	152,121,770	94,861,772	18,611,775	265,595,317	35,743,859	(3,523,694)	3,444,359	301,259,840
MEDICAL EXPENSES								
Provider Capitation	40,174,197	44,794,530	9,590,834	94,559,560	16,578,078	(1,589,233)		109,548,405
Facilities	18,445,717	17,404,296	3,522,010	39,372,022	4,822,064	230,958	713,203	45,138,248
Professional Claims	17,988,605	6,906,821	1,452,234	26,347,660	792,924	40,434	655,933	27,836,951
Prescription Drugs	20,832,658	23,769,151	6,207,790	50,809,599	6,484,788	462,431	326,386	58,083,205
MLTSS	33,881,041	2,544,002	1,430,600	37,855,643	1,283,428	70,265	14,365	39,223,701
Medical Management	2,211,933	1,330,797	144,008	3,686,739	1,662,106	82,781	792,670	6,224,296
Quality Incentives	1,303,180	672,208	151,996	2,127,385	197,280		5,038	2,329,702
Reinsurance & Other	697,468	704,372	24,088	1,425,928	112,359		151,322	1,689,609
Total Medical Expenses	135,534,799	98,126,176	22,523,560	256,184,536	31,933,027	(702,363)	2,658,917	290,074,117
Medical Loss Ratio	89.1%	103.4%	121.0%	96.5%	89.3%	19.9%	77.2%	96.3%
GROSS MARGIN	**16,586,971**	**(3,264,405)**	**(3,911,785)**	**9,410,781**	**3,810,832**	**(2,821,331)**	**785,442**	**11,185,723**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,819,524	775,814	75,644	166,678	7,837,660
Professional fees				278,612	16,388	15,000	123	310,122
Purchased services				1,250,112	90,338	8,221	16,401	1,365,073
Printing & Postage				495,407	160,886	7,443	(4,350)	659,386
Depreciation & Amortization				520,335			2,126	522,462
Other expenses				1,571,187	38,228	235	4,267	1,613,918
Indirect cost allocation & Occupancy				(231,842)	552,199	37,170	4,221	361,750
Total Administrative Expenses				10,703,335	1,633,854	143,714	189,467	12,670,370
Admin Loss Ratio				4.0%	4.6%	-4.1%	5.5%	4.2%
INCOME (LOSS) FROM OPERATIONS				(1,292,554)	2,176,977	(2,965,045)	595,974	(1,484,647)
INVESTMENT INCOME								7,295,643
TOTAL MCO TAX				468,141				468,141
TOTAL GRANT INCOME				9,275				9,275
OTHER INCOME				19				19
CHANGE IN NET ASSETS				**$ (815,119)**	**$ 2,176,977**	**$ (2,965,045)**	**$ 595,974**	**$ 6,288,430**
BUDGETED CHANGE IN NET ASSETS				1,571,558	(1,049,801)	(90,637)	260,862	1,941,982
VARIANCE TO BUDGET - FAV (UNFAV)				$ (2,386,677)	$ 3,226,778	$ (2,874,408)	$ 335,112	$ 4,346,448

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Consolidated Revenue & Expense: April 2020 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	4,823,730	2,278,413	114,563	7,216,706	141,458	14,696	3,765	7,376,625
REVENUES								
Capitation Revenue	1,581,112,199	$ 1,121,705,243	$ 224,672,436	$ 2,927,489,878	$ 258,000,413	$ 11,848,935	$ 30,655,803	$ 3,227,995,029
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,581,112,199	1,121,705,243	224,672,436	2,927,489,878	258,000,413	11,848,935	30,655,803	3,227,995,029
MEDICAL EXPENSES								
Provider Capitation	389,334,386	438,738,474	99,833,271	927,906,131	115,457,625	2,719,984		1,046,083,739
Facilities	245,138,905	212,914,107	52,470,538	510,523,550	38,363,282	4,051,948	6,631,383	559,570,163
Professional Claims	179,727,936	70,822,749	14,730,397	265,281,082	7,597,447	506,844	5,720,504	279,105,877
Prescription Drugs	196,167,702	204,156,972	56,831,979	457,156,653	57,420,626	5,091,638	2,449,491	522,118,409
MLTSS	341,685,068	26,165,829	16,525,015	384,375,912	13,363,945	230,645	345,841	398,316,343
Medical Management	21,254,128	12,677,360	2,540,282	36,471,769	10,933,825	417,967	7,344,234	55,167,796
Quality Incentives	9,515,592	4,820,940	1,422,008	15,758,540	2,011,780		201,272	17,971,592
Reinsurance & Other	122,777,330	89,749,991	331,649	212,858,970	1,772,331		2,024,172	216,655,473
Total Medical Expenses	1,505,601,048	1,060,046,421	244,685,138	2,810,332,607	246,920,862	13,019,026	24,716,897	3,094,989,393
Medical Loss Ratio	95.2%	94.5%	108.9%	96.0%	95.7%	109.9%	80.6%	95.9%
GROSS MARGIN	**75,511,151**	**61,658,822**	**(20,012,702)**	**117,157,271**	**11,079,551**	**(1,170,091)**	**5,938,906**	**133,005,636**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				64,815,615	7,225,803	671,254	1,428,944	74,141,617
Professional fees				2,051,940	476,873	189,371	1,629	2,719,814
Purchased services				8,564,998	1,354,776	127,949	87,928	10,135,651
Printing & Postage				3,526,094	705,378	50,189	101,296	4,382,957
Depreciation & Amortization				3,526,697			20,840	3,547,537
Other expenses				14,758,317	320,177	2,472	39,427	15,120,393
Indirect cost allocation & Occupancy				(2,591,992)	5,580,749	384,976	42,970	3,416,704
Total Administrative Expenses				94,651,669	15,663,757	1,426,212	1,723,035	113,464,673
Admin Loss Ratio				3.2%	6.1%	12.0%	5.6%	3.5%
INCOME (LOSS) FROM OPERATIONS				22,505,601	(4,584,206)	(2,596,303)	4,215,871	19,540,963
INVESTMENT INCOME								36,489,999
TOTAL MCO TAX				(1,344,218)				(1,344,218)
TOTAL GRANT INCOME				(38,473)				(38,473)
OTHER INCOME				562				562
CHANGE IN NET ASSETS				**$ 21,123,472**	**$ (4,584,206)**	**$ (2,596,303)**	**$ 4,215,871**	**$ 54,648,832**
BUDGETED CHANGE IN NET ASSETS				23,967,680	(12,560,527)	(1,089,459)	1,912,310	24,730,004
VARIANCE TO BUDGET - FAV (UNFAV)				$ (2,844,208)	$ 7,976,321	$ (1,506,844)	$ 2,303,561	$ 29,918,828

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Balance Sheet:
As of April 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$377,294,987	Accounts Payable	$52,266,269
Investments	599,785,270	Medical Claims liability	772,950,933
Capitation receivable	418,197,504	Accrued Payroll Liabilities	15,448,856
Receivables - Other	37,451,464	Deferred Revenue	112,165,015
Prepaid expenses	7,902,477	Deferred Lease Obligations	170,710
		Capitation and Withholds	137,990,680
Total Current Assets	**1,440,631,702**	**Total Current Liabilities**	**1,090,992,463**
Capital Assets			
Furniture & Equipment	39,639,800		
Building/Leasehold Improvements	8,130,537		
505 City Parkway West	51,616,611		
	99,386,947		
Less: accumulated depreciation	(52,210,123)		
Capital assets, net	47,176,824	Other (than pensions) post employment benefits liability	25,928,611
Other Assets		Net Pension Liabilities	23,577,504
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,140,498,578**
Cash and Cash Equivalents	5,602,956		
Long-term Investments	575,096,270	Deferred Inflows	
Total Board-designated Assets	580,699,226	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	639,198,139	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,127,006,666**	TNE	101,413,430
		Funds in Excess of TNE	888,778,272
Deferred Outflows		**TOTAL NET POSITION**	990,191,702
Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,138,097,115**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,138,097,115**

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Board Designated Reserve and TNE Analysis
As of April 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	158,992,291				
	Tier 1 - Logan Circle	157,834,956				
	Tier 1 - Wells Capital	158,293,123				
Board-designated Reserve		475,120,371	324,555,816	507,114,064	150,564,555	(31,993,693)
TNE Requirement	Tier 2 - Logan Circle	105,578,855	101,413,430	101,413,430	4,165,426	4,165,426
	Consolidated:	580,699,226	425,969,246	608,527,494	154,729,980	(27,828,268)
	Current reserve level	*1.91*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

April 2020

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CalOptima - Consolidated
Financial Highlights
For the Ten Months Ended April 30, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
737,154	737,600	(446)	(0.1%)	Member Months	7,376,625	7,451,541	(74,916)	(1.0%)
301,259,840	297,010,806	4,249,034	1.4%	Revenues	3,227,995,029	2,972,293,296	255,701,732	8.6%
290,074,117	282,377,707	(7,696,411)	(2.7%)	Medical Expenses	3,094,989,393	2,829,269,272	(265,720,120)	(9.4%)
12,670,370	13,941,118	1,270,748	9.1%	Administrative Expenses	113,464,673	130,794,020	17,329,347	13.2%
(1,484,647)	**691,982**	**(2,176,629)**	**(314.6%)**	**Operating Margin**	**19,540,963**	**12,230,004**	**7,310,959**	**59.8%**
7,773,077	1,250,000	6,523,077	521.8%	Non Operating Income (Loss)	35,107,869	12,500,000	22,607,869	180.9%
6,288,430	**1,941,982**	**4,346,448**	**223.8%**	**Change in Net Assets**	**54,648,832**	**24,730,004**	**29,918,828**	**121.0%**
96.3%	95.1%	(1.2%)		Medical Loss Ratio	95.9%	95.2%	(0.7%)	
4.2%	4.7%	0.5%		Administrative Loss Ratio	3.5%	4.4%	0.9%	
(0.5%)	0.2%	(0.7%)		Operating Margin Ratio	0.6%	0.4%	0.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
				*Administrative Loss Ratio (excluding Directed Payments)	3.7%			

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Ten Months Ended April 30, 2020

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	721,236	721,815	(579)	(0.1%)
OneCare Connect	14,151	13,858	293	2.1%
OneCare	1,364	1,515	(151)	(10.0%)
PACE	403	412	(9)	(2.2%)
Total	737,154	737,600	(446)	(0.1%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (815)	$ 1,572	$ (2,387)	(151.8%)
OneCare Connect	2,177	(1,050)	3,227	307.3%
OneCare	(2,965)	(91)	(2,874)	(3158.2%)
PACE	596	261	335	128.5%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	7,296	1,250	6,046	483.7%
Total	$ 6,289	$ 1,942	$ 4,347	223.8%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.5%	95.0%	(1.5)
OneCare Connect	89.3%	97.0%	7.6
OneCare	19.9%	96.4%	76.5

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 10,703	$ 11,827	$ 1,124	9.5%
OneCare Connect	1,634	1,777	143	8.0%
OneCare	144	149	5	3.7%
PACE	189	189	(1)	(0.5%)
Total	$ 12,670	$ 13,941	$ 1,271	9.1%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,076	1,183	107
OneCare Connect	201	211	10
OneCare	10	9	(1)
PACE	80	93	12
Total	1,367	1,496	129

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	670	610	60
OneCare Connect	70	66	5
OneCare	136	163	(27)
PACE	5	4	1
Total	882	843	38

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	7,216,706	7,292,390	(75,684)	(1.0%)
OneCare Connect	141,458	140,358	1,100	0.8%
OneCare	14,696	15,044	(348)	(2.3%)
PACE	3,765	3,749	16	0.4%
Total	7,376,625	7,451,541	(74,916)	(1.0%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 21,123	$ 23,968	$ (2,844)	(11.9%)
OneCare Connect	(4,584)	(12,561)	7,976	63.5%
OneCare	(2,596)	(1,089)	(1,507)	(138.3%)
PACE	4,216	1,912	2,304	120.5%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	36,490	12,500	23,990	191.9%
Total	$ 54,649	$ 24,730	$ 29,919	121.0%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.0%	95.0%	(1.0)
OneCare Connect	95.7%	97.7%	2.0
OneCare	109.9%	97.7%	(12.2)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 94,652	$ 109,516	$ 14,864	13.6%
OneCare Connect	15,664	17,974	2,310	12.9%
OneCare	1,426	1,473	47	3.2%
PACE	1,723	1,832	109	5.9%
Total	$ 113,465	$ 130,794	$ 17,329	13.2%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	10,412	11,680	1,267
OneCare Connect	1,934	2,062	127
OneCare	95	93	(2)
PACE	733	921	188
Total	13,175	14,755	1,580

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	693	624	69
OneCare Connect	73	68	5
OneCare	154	162	(8)
PACE	5	4	1
Total	925	858	67

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended April 30, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	737,154		737,600		(446)	
REVENUE						
Medi-Cal	$ 265,595,317	$ 368.25	$ 268,240,791	$ 371.62	$ (2,645,475)	$ (3.37)
OneCare Connect	35,743,859	2,525.89	23,941,163	1,727.61	11,802,696	798.28
OneCare	(3,523,694)	(2,583.35)	1,638,767	1,081.69	(5,162,461)	(3,665.04)
PACE	3,444,359	8,546.80	3,190,085	7,742.92	254,274	803.88
Total Operating Revenue	301,259,840	408.68	297,010,806	402.67	4,249,034	6.01
MEDICAL EXPENSES						
Medi-Cal	256,184,536	355.20	254,842,361	353.06	(1,342,175)	(2.14)
OneCare Connect	31,933,027	2,256.59	23,214,423	1,675.16	(8,718,604)	(581.43)
OneCare	(702,363)	(514.93)	1,580,209	1,043.04	2,282,572	1,557.97
PACE	2,658,917	6,597.81	2,740,714	6,652.22	81,797	54.41
Total Medical Expenses	290,074,117	393.51	282,377,707	382.83	(7,696,411)	(10.68)
GROSS MARGIN	11,185,723	15.17	14,633,100	19.84	(3,447,377)	(4.67)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,837,660	10.63	8,494,427	11.52	656,767	0.89
Professional fees	310,122	0.42	517,751	0.70	207,629	0.28
Purchased services	1,365,073	1.85	1,536,360	2.08	171,287	0.23
Printing & Postage	659,386	0.89	521,297	0.71	(138,089)	(0.18)
Depreciation & Amortization	522,462	0.71	457,866	0.62	(64,596)	(0.09)
Other expenses	1,613,918	2.19	2,036,844	2.76	422,926	0.57
Indirect cost allocation & Occupancy expense	361,750	0.49	376,573	0.51	14,823	0.02
Total Administrative Expenses	12,670,370	17.19	13,941,118	18.90	1,270,748	1.71
INCOME (LOSS) FROM OPERATIONS	(1,484,647)	(2.01)	691,982	0.94	(2,176,629)	(2.95)
INVESTMENT INCOME						
Interest income	1,276,141	1.73	1,250,000	1.69	26,141	0.04
Realized gain/(loss) on investments	1,131,624	1.54	-	-	1,131,624	1.54
Unrealized gain/(loss) on investments	4,887,878	6.63	-	-	4,887,878	6.63
Total Investment Income	7,295,643	9.90	1,250,000	1.69	6,045,643	8.21
TOTAL MCO TAX	468,141	0.64	-	-	468,141	0.64
TOTAL GRANT INCOME	9,275	0.01	-	-	9,275	0.01
OTHER INCOME	19	-	-	-	19	-
CHANGE IN NET ASSETS	**6,288,430**	**8.53**	**1,941,982**	**2.63**	**4,346,448**	**5.90**
MEDICAL LOSS RATIO	**96.3%**		**95.1%**		**(1.2%)**	
ADMINISTRATIVE LOSS RATIO	**4.2%**		**4.7%**		**0.5%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	7,376,625		7,451,541		(74,916)	
REVENUE						
Medi-Cal	$ 2,927,489,878	$ 405.65	$ 2,687,718,486	$ 368.56	$ 239,771,392	$ 37.09
OneCare Connect	258,000,413	1,823.87	239,083,586	1,703.38	18,916,827	120.49
OneCare	11,848,935	806.27	16,385,747	1,089.19	(4,536,812)	(282.92)
PACE	30,655,803	8,142.31	29,105,477	7,763.53	1,550,326	378.78
Total Operating Revenue	3,227,995,029	437.60	2,972,293,296	398.88	255,701,732	38.72
MEDICAL EXPENSES						
Medi-Cal	2,810,332,607	389.42	2,554,234,784	350.26	(256,097,823)	(39.16)
OneCare Connect	246,920,862	1,745.54	233,670,606	1,664.82	(13,250,256)	(80.72)
OneCare	13,019,026	885.89	16,002,266	1,063.70	2,983,240	177.81
PACE	24,716,897	6,564.91	25,361,616	6,764.90	644,719	199.99
Total Medical Expenses	3,094,989,393	419.57	2,829,269,272	379.69	(265,720,120)	(39.88)
GROSS MARGIN	133,005,636	18.03	143,024,024	19.19	(10,018,388)	(1.16)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	74,141,617	10.05	81,674,044	10.96	7,532,427	0.91
Professional fees	2,719,814	0.37	4,817,731	0.65	2,097,917	0.28
Purchased services	10,135,651	1.37	12,737,594	1.71	2,601,943	0.34
Printing & Postage	4,382,957	0.59	5,570,995	0.75	1,188,038	0.16
Depreciation & Amortization	3,547,537	0.48	4,578,660	0.61	1,031,123	0.13
Other expenses	15,120,393	2.05	17,595,147	2.36	2,474,754	0.31
Indirect cost allocation & Occupancy expense	3,416,704	0.46	3,819,849	0.51	403,145	0.05
Total Administrative Expenses	113,464,673	15.38	130,794,020	17.55	17,329,347	2.17
INCOME (LOSS) FROM OPERATIONS	19,540,963	2.65	12,230,004	1.64	7,310,959	1.01
INVESTMENT INCOME						
Interest income	26,246,349	3.56	12,500,000	1.68	13,746,349	1.88
Realized gain/(loss) on investments	3,619,422	0.49	-	-	3,619,422	0.49
Unrealized gain/(loss) on investments	6,624,227	0.90	-	-	6,624,227	0.90
Total Investment Income	36,489,999	4.95	12,500,000	1.68	23,989,999	3.27
TOTAL MCO TAX	(1,344,218)	(0.18)	-	-	(1,344,218)	(0.18)
TOTAL GRANT INCOME	(38,473)	(0.01)	-	-	(38,473)	(0.01)
OTHER INCOME	562	-	-	-	562	-
CHANGE IN NET ASSETS	**54,648,832**	**7.41**	**24,730,004**	**3.32**	**29,918,828**	**4.09**
MEDICAL LOSS RATIO	**95.9%**		**95.2%**		**(0.7%)**	
ADMINISTRATIVE LOSS RATIO	**3.5%**		**4.4%**		**0.9%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended April 30, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	481,740	228,466	11,030	721,236	14,151	1,364	403	737,154
REVENUES								
Capitation Revenue	152,121,770	$ 94,861,772	$ 18,611,775	$ 265,595,317	$ 35,743,859	$ (3,523,694)	$ 3,444,359	$ 301,259,840
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	152,121,770	94,861,772	18,611,775	265,595,317	35,743,859	(3,523,694)	3,444,359	301,259,840
MEDICAL EXPENSES								
Provider Capitation	40,174,197	44,794,530	9,590,834	94,559,560	16,578,078	(1,589,233)		109,548,405
Facilities	18,445,717	17,404,296	3,522,010	39,372,022	4,822,064	230,958	713,203	45,138,248
Professional Claims	17,988,605	6,906,821	1,452,234	26,347,660	792,924	40,434	655,933	27,836,951
Prescription Drugs	20,832,658	23,769,151	6,207,790	50,809,599	6,484,788	462,431	326,386	58,083,205
MLTSS	33,881,041	2,544,002	1,430,600	37,855,643	1,283,428	70,265	14,365	39,223,701
Medical Management	2,211,933	1,330,797	144,008	3,686,739	1,662,106	82,781	792,670	6,224,296
Quality Incentives	1,303,180	672,208	151,996	2,127,385	197,280		5,038	2,329,702
Reinsurance & Other	697,468	704,372	24,088	1,425,928	112,359		151,322	1,689,609
Total Medical Expenses	135,534,799	98,126,176	22,523,560	256,184,536	31,933,027	(702,363)	2,658,917	290,074,117
Medical Loss Ratio	89.1%	103.4%	121.0%	96.5%	89.3%	19.9%	77.2%	96.3%
GROSS MARGIN	**16,586,971**	**(3,264,405)**	**(3,911,785)**	**9,410,781**	**3,810,832**	**(2,821,331)**	**785,442**	**11,185,723**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,819,524	775,814	75,644	166,678	7,837,660
Professional fees				278,612	16,388	15,000	123	310,122
Purchased services				1,250,112	90,338	8,221	16,401	1,365,073
Printing & Postage				495,407	160,886	7,443	(4,350)	659,386
Depreciation & Amortization				520,335			2,126	522,462
Other expenses				1,571,187	38,228	235	4,267	1,613,918
Indirect cost allocation & Occupancy				(231,842)	552,199	37,170	4,221	361,750
Total Administrative Expenses				10,703,335	1,633,854	143,714	189,467	12,670,370
Admin Loss Ratio				4.0%	4.6%	-4.1%	5.5%	4.2%
INCOME (LOSS) FROM OPERATIONS				(1,292,554)	2,176,977	(2,965,045)	595,974	(1,484,647)
INVESTMENT INCOME								7,295,643
TOTAL MCO TAX				468,141				468,141
TOTAL GRANT INCOME				9,275				9,275
OTHER INCOME				19				19
CHANGE IN NET ASSETS				**$ (815,119)**	**$ 2,176,977**	**$ (2,965,045)**	**$ 595,974**	**$ 6,288,430**
BUDGETED CHANGE IN NET ASSETS				1,571,558	(1,049,801)	(90,637)	260,862	1,941,982
VARIANCE TO BUDGET - FAV (UNFAV)				$ (2,386,677)	$ 3,226,778	$ (2,874,408)	$ 335,112	$ 4,346,448

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Ten Months Ended April 30, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	4,823,730	2,278,413	114,563	7,216,706	141,458	14,696	3,765	7,376,625
REVENUES								
Capitation Revenue	1,581,112,199	$ 1,121,705,243	$ 224,672,436	$ 2,927,489,878	$ 258,000,413	$ 11,848,935	$ 30,655,803	$ 3,227,995,029
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,581,112,199	1,121,705,243	224,672,436	2,927,489,878	258,000,413	11,848,935	30,655,803	3,227,995,029
MEDICAL EXPENSES								
Provider Capitation	389,334,386	438,738,474	99,833,271	927,906,131	115,457,625	2,719,984		1,046,083,739
Facilities	245,138,905	212,914,107	52,470,538	510,523,550	38,363,282	4,051,948	6,631,383	559,570,163
Professional Claims	179,727,936	70,822,749	14,730,397	265,281,082	7,597,447	506,844	5,720,504	279,105,877
Prescription Drugs	196,167,702	204,156,972	56,831,979	457,156,653	57,420,626	5,091,638	2,449,491	522,118,409
MLTSS	341,685,068	26,165,829	16,525,015	384,375,912	13,363,945	230,645	345,841	398,316,343
Medical Management	21,254,128	12,677,360	2,540,282	36,471,769	10,933,825	417,967	7,344,234	55,167,796
Quality Incentives	9,515,592	4,820,940	1,422,008	15,758,540	2,011,780		201,272	17,971,592
Reinsurance & Other	122,777,330	89,749,991	331,649	212,858,970	1,772,331		2,024,172	216,655,473
Total Medical Expenses	1,505,601,048	1,060,046,421	244,685,138	2,810,332,607	246,920,862	13,019,026	24,716,897	3,094,989,393
Medical Loss Ratio	95.2%	94.5%	108.9%	96.0%	95.7%	109.9%	80.6%	95.9%
GROSS MARGIN	**75,511,151**	**61,658,822**	**(20,012,702)**	**117,157,271**	**11,079,551**	**(1,170,091)**	**5,938,906**	**133,005,636**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				64,815,615	7,225,803	671,254	1,428,944	74,141,617
Professional fees				2,051,940	476,873	189,371	1,629	2,719,814
Purchased services				8,564,998	1,354,776	127,949	87,928	10,135,651
Printing & Postage				3,526,094	705,378	50,189	101,296	4,382,957
Depreciation & Amortization				3,526,697			20,840	3,547,537
Other expenses				14,758,317	320,177	2,472	39,427	15,120,393
Indirect cost allocation & Occupancy				(2,591,992)	5,580,749	384,976	42,970	3,416,704
Total Administrative Expenses				94,651,669	15,663,757	1,426,212	1,723,035	113,464,673
Admin Loss Ratio				3.2%	6.1%	12.0%	5.6%	3.5%
INCOME (LOSS) FROM OPERATIONS				22,505,601	(4,584,206)	(2,596,303)	4,215,871	19,540,963
INVESTMENT INCOME								36,489,999
TOTAL MCO TAX				(1,344,218)				(1,344,218)
TOTAL GRANT INCOME				(38,473)				(38,473)
OTHER INCOME				562				562
CHANGE IN NET ASSETS				**$ 21,123,472**	**$ (4,584,206)**	**$ (2,596,303)**	**$ 4,215,871**	**$ 54,648,832**
BUDGETED CHANGE IN NET ASSETS				23,967,680	(12,560,527)	(1,089,459)	1,912,310	24,730,004
VARIANCE TO BUDGET - FAV (UNFAV)				$ (2,844,208)	$ 7,976,321	$ (1,506,844)	$ 2,303,561	$ 29,918,828

April 30, 2020 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $6.3 million, $4.3 million favorable to budget
- Operating deficit is $1.5 million, with a surplus in non-operating income of $7.8 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $54.6 million, $29.9 million favorable to budget
- Operating surplus is $19.5 million, with a surplus in non-operating income of $35.1 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(1.3)	1.6	(2.9)	Medi-Cal	22.5	24.0	(1.5)
2.2	(1.0)	3.2	OCC	(4.6)	(12.6)	8.0
(3.0)	(0.1)	(2.9)	OneCare	(2.6)	(1.1)	(1.5)
0.6	0.3	0.3	PACE	4.2	1.9	2.3
(1.5)	**0.7**	**(2.2)**	**Operating**	**19.5**	**12.2**	**7.3**
7.8	1.3	6.5	Inv./Rental Inc, MCO tax	35.1	12.5	22.6
7.8	**1.3**	**6.5**	**Non-Operating**	**35.1**	**12.5**	**22.6**
6.3	**1.9**	**4.3**	**TOTAL**	**54.6**	**24.7**	**29.9**

CalOptima - Consolidated
Enrollment Summary
For the Ten Months Ended April 30, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
66,772	66,372	400	0.6%	Aged	659,753	657,802	1,951	0.3%
513	615	(102)	(16.6%)	BCCTP	5,286	6,150	(864)	(14.0%)
45,058	43,552	1,506	3.5%	Disabled	447,946	437,090	10,856	2.5%
280,927	275,292	5,635	2.0%	TANF Child	2,817,557	2,814,109	3,448	0.1%
84,912	83,808	1,104	1.3%	TANF Adult	858,287	859,426	(1,139)	(0.1%)
3,558	3,404	154	4.5%	LTC	34,900	34,040	860	2.5%
228,466	235,832	(7,366)	(3.1%)	MCE	2,278,413	2,354,373	(75,960)	(3.2%)
11,030	12,940	(1,910)	(14.8%)	WCM	114,563	129,400	(14,837)	(11.5%)
721,236	**721,815**	**(579)**	**(0.1%)**	**Medi-Cal Total**	**7,216,706**	**7,292,390**	**(75,684)**	**(1.0%)**
14,151	**13,858**	**293**	**2.1%**	**OneCare Connect**	**141,458**	**140,358**	**1,100**	**0.8%**
1,364	**1,515**	**(151)**	**(10.0%)**	**OneCare**	**14,696**	**15,044**	**(348)**	**(2.3%)**
403	**412**	**(9)**	**(2.2%)**	**PACE**	**3,765**	**3,749**	**16**	**0.4%**
737,154	**737,600**	**(446)**	**(0.1%)**	**CalOptima Total**	**7,376,625**	**7,451,541**	**(74,916)**	**(1.0%)**
				Enrollment (by Network)				
160,311	160,256	55	0.0%	HMO	1,591,478	1,618,152	(26,674)	(1.6%)
205,307	204,975	332	0.2%	PHC	2,055,188	2,083,372	(28,184)	(1.4%)
170,083	184,683	(14,600)	(7.9%)	Shared Risk Group	1,756,013	1,867,827	(111,814)	(6.0%)
185,535	171,901	13,634	7.9%	Fee for Service	1,814,026	1,723,039	90,987	5.3%
721,236	**721,815**	**(579)**	**(0.1%)**	**Medi-Cal Total**	**7,216,706**	**7,292,390**	**(75,684)**	**(1.0%)**
14,151	**13,858**	**293**	**2.1%**	**OneCare Connect**	**141,458**	**140,358**	**1,100**	**0.8%**
1,364	**1,515**	**(151)**	**(10.0%)**	**OneCare**	**14,696**	**15,044**	**(348)**	**(2.3%)**
403	**412**	**(9)**	**(2.2%)**	**PACE**	**3,765**	**3,749**	**16**	**0.4%**
737,154	**737,600**	**(446)**	**(0.1%)**	**CalOptima Total**	**7,376,625**	**7,451,541**	**(74,916)**	**(1.0%)**

CalOptima
Enrollment Trend by Network
For the Ten Months Ended April 30, 2020

	July-19	August-19	September-19	October-19	November-19	December-19	January-20	February-20	March-20	April-20	YTD Actual	YTD Budget	Variance
HMOs													
Aged	3,723	3,740	3,754	3,821	3,827	3,743	3,768	3,625	3,679	3,746	37,426	37,942	(516)
BCCTP	1	1	2	2	1	1	1	1	1	1	12	10	2
Disabled	6,539	6,547	6,572	6,613	6,633	6,546	6,468	6,612	6,670	6,713	65,913	66,276	(363)
TANF Child	54,046	53,703	52,620	53,069	52,791	51,642	50,877	50,743	51,816	52,360	523,667	525,604	(1,937)
TANF Adult	27,944	27,740	27,446	27,279	27,012	27,168	25,104	25,208	25,961	26,474	267,336	275,950	(8,614)
LTC	2	1	3	3	2	4		5	1	1	22	20	2
MCE	68,973	69,077	68,729	68,881	68,361	68,256	62,418	66,229	67,457	69,104	677,485	688,720	(11,235)
WCM	2,026	2,087	2,052	1,987	2,006	2,024	1,692	1,937	1,894	1,912	19,617	23,630	(4,013)
Total	**163,254**	**162,896**	**161,178**	**161,655**	**160,633**	**159,384**	**150,328**	**154,360**	**157,479**	**160,311**	**1,591,478**	**1,618,152**	**(26,674)**
PHCs													
Aged	1,548	1,540	1,524	1,542	1,577	1,579	1,516	1,448	1,474	1,493	15,241	15,202	39
BCCTP											-		0
Disabled	5,416	5,499	5,323	5,425	5,500	5,474	5,244	5,422	5,436	5,482	54,221	53,288	933
TANF Child	148,665	148,131	143,994	146,390	145,734	140,237	143,833	140,195	142,951	144,407	1,444,537	1,460,425	(15,888)
TANF Adult	11,149	11,322	10,925	10,865	10,743	11,285	9,797	9,907	10,366	10,489	106,848	100,757	6,091
LTC			1		1	1	2	2	1		8		8
MCE	37,510	37,479	37,084	37,037	36,728	36,708	33,716	35,640	36,168	36,723	364,793	376,860	(12,067)
WCM	7,209	7,276	7,190	7,151	7,070	6,994	6,371	6,803	6,763	6,713	69,540	76,840	(7,300)
Total	**211,497**	**211,247**	**206,041**	**208,410**	**207,353**	**202,278**	**200,479**	**199,417**	**203,159**	**205,307**	**2,055,188**	**2,083,372**	**(28,184)**
Shared Risk Groups													
Aged	3,569	3,523	3,470	3,501	3,527	3,364	3,301	3,225	3,223	3,226	33,929	36,252	(2,323)
BCCTP						1	(1)	1			1		1
Disabled	7,275	7,294	7,144	7,177	7,200	7,139	6,724	7,092	7,010	6,980	71,035	67,892	3,143
TANF Child	63,291	62,381	57,001	59,579	58,690	56,771	56,508	54,614	55,822	56,162	580,819	612,245	(31,426)
TANF Adult	28,681	28,390	27,842	27,428	26,946	27,269	24,473	24,861	25,641	26,092	267,623	283,448	(15,825)
LTC	1	3	3	2	1	1		1	1		13	10	3
MCE	84,595	83,922	82,492	81,749	80,096	79,714	69,637	73,826	74,815	76,187	787,033	848,310	(61,277)
WCM	1,732	1,706	1,620	1,598	1,581	1,593	1,367	1,457	1,470	1,436	15,560	19,670	(4,110)
Total	**189,144**	**187,219**	**179,572**	**181,034**	**178,041**	**175,852**	**162,009**	**165,077**	**167,982**	**170,083**	**1,756,013**	**1,867,827**	**(111,814)**
Fee for Service (Dual)													
Aged	51,730	52,454	52,097	52,050	52,649	51,770	54,711	52,919	52,855	53,118	526,353	523,045	3,308
BCCTP	15	18	17	18	19	20	13	10	12	12	154	180	(26)
Disabled	20,752	20,053	20,586	20,577	20,781	20,848	20,986	20,729	21,085	20,778	207,175	205,150	2,025
TANF Child		19	1	1	1	1	1	1	1	1	27		27
TANF Adult	964	1,923	949	941	963	938	1,528	917	847	834	10,804	8,753	2,051
LTC	3,044	3,097	3,061	3,161	3,204	2,971	3,389	3,142	3,157	3,192	31,418	30,490	928
MCE	2,116	2,171	1,935	1,717	1,737	2,255	876	1,084	1,135	1,144	16,170	20,650	(4,480)
WCM	15	15	15	16	15	16	15	14	13	13	147	160	(13)
Total	**78,636**	**79,750**	**78,661**	**78,481**	**79,369**	**78,819**	**81,519**	**78,816**	**79,105**	**79,092**	**792,248**	**788,428**	**3,820**
Fee for Service (Non-Dual - Total)													
Aged	4,682	4,211	4,370	4,583	4,890	3,841	4,864	5,163	5,011	5,189	46,804	45,361	1,443
BCCTP	550	542	484	532	525	518	506	473	489	500	5,119	5,960	(841)
Disabled	4,928	5,692	4,374	4,930	5,428	8,670	483	5,084	4,908	5,105	49,602	44,484	5,118
TANF Child	25,571	32,106	16,125	25,295	29,914	21,194	32,748	29,586	27,971	27,997	268,507	215,835	52,672
TANF Adult	19,658	19,951	19,512	19,854	23,011	22,542	18,203	21,106	20,816	21,023	205,676	190,518	15,158
LTC	328	326	331	347	364	302	358	359	359	365	3,439	3,520	(81)
MCE	40,680	41,152	40,342	41,308	48,994	48,138	37,208	44,795	45,007	45,308	432,932	419,833	13,099
WCM	843	960	978	1,008	1,079	874	936	1,043	1,022	956	9,699	9,100	599
Total	**97,240**	**104,940**	**86,516**	**97,857**	**114,205**	**106,079**	**95,306**	**107,609**	**105,583**	**106,443**	**1,021,778**	**934,611**	**87,167**
Grand Totals													
Aged	65,252	65,468	65,215	65,497	66,470	64,297	68,160	66,380	66,242	66,772	659,753	657,802	1,951
BCCTP	566	561	503	552	545	540	519	485	502	513	5,286	6,150	(864)
Disabled	44,910	45,085	43,999	44,722	45,542	48,677	39,905	44,939	45,109	45,058	447,946	437,090	10,856
TANF Child	291,573	296,340	269,741	284,334	287,130	269,845	283,967	275,139	278,561	280,927	2,817,557	2,814,109	3,448
TANF Adult	88,396	89,326	86,674	86,367	88,675	89,202	79,105	81,999	83,631	84,912	858,287	859,426	(1,139)
LTC	3,375	3,427	3,399	3,513	3,572	3,279	3,749	3,509	3,519	3,558	34,900	34,040	860
MCE	233,874	233,801	230,582	230,692	235,916	235,071	203,855	221,574	224,582	228,466	2,278,413	2,354,373	(75,960)
WCM	11,825	12,044	11,855	11,760	11,751	11,501	10,381	11,254	11,162	11,030	114,563	129,400	(14,837)
Total MediCal MM	**739,771**	**746,052**	**711,968**	**727,437**	**739,601**	**722,412**	**689,641**	**705,279**	**713,308**	**721,236**	**7,216,706**	**7,292,390**	**(75,684)**
OneCare Connect	**14,257**	**14,090**	**14,186**	**14,093**	**14,065**	**14,264**	**14,104**	**14,171**	**14,077**	**14,151**	**141,458**	**140,358**	**1,100**
OneCare	**1,530**	**1,545**	**1,564**	**1,567**	**1,498**	**1,465**	**1,417**	**1,382**	**1,364**	**1,364**	**14,696**	**15,044**	**(348)**
PACE	**335**	**345**	**356**	**368**	**375**	**393**	**394**	**396**	**400**	**403**	**3,765**	**3,749**	**16**
Grand Total	**755,893**	**762,032**	**728,074**	**743,465**	**755,539**	**738,534**	**705,556**	**721,228**	**729,149**	**737,154**	**7,376,625**	**7,451,541**	**(74,916)**

ENROLLMENT:

Overall, April enrollment was 737,154

- Unfavorable to budget 446 or 0.1%
- Increased 8,005 or 1.1% from prior month (PM) (March 2020)
- Decreased 23,743 or 3.1% from prior year (PY) (April 2019)

Medi-Cal enrollment was 721,236

- Unfavorable to budget 579 or 0.1%
  - Medi-Cal Expansion (MCE) unfavorable 7,366
  - Whole Child Model (WCM unfavorable 1,910
  - Temporary Assistance for Needy Families (TANF) favorable 6,739
  - Seniors and Persons with Disabilities (SPD) favorable 1,804
  - Long-Term Care (LTC) favorable 154
- Increased 7,928 from PM

OneCare Connect enrollment was 14,151

- Favorable to budget 293 or 2.1%
- Increased 74 from PM

OneCare enrollment was 1,364

- Unfavorable to budget 151 or 10.0%
- No change from PM

PACE enrollment was 403

- Unfavorable to budget 9 or 2.2%
- Increased 3 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
721,236	**721,815**	**(579)**	**(0.1%)**	**Member Months**	**7,216,706**	**7,292,390**	**(75,684)**	**(1.0%)**
				Revenues				
265,595,317	268,240,791	(2,645,475)	(1.0%)	Capitation Revenue	2,927,489,878	2,687,718,486	239,771,392	8.9%
-	-	-	0.0%	Other Income	-	-	-	0.0%
265,595,317	**268,240,791**	**(2,645,475)**	**(1.0%)**	**Total Operating Revenue**	**2,927,489,878**	**2,687,718,486**	**239,771,392**	**8.9%**
				Medical Expenses				
96,686,945	95,013,073	(1,673,872)	(1.8%)	Provider Capitation	943,664,671	950,980,785	7,316,115	0.8%
39,372,022	47,990,964	8,618,942	18.0%	Facilities Claims	510,523,550	482,707,733	(27,815,817)	(5.8%)
26,347,660	22,981,998	(3,365,662)	(14.6%)	Professional Claims	265,281,082	231,074,276	(34,206,806)	(14.8%)
50,809,599	43,360,858	(7,448,742)	(17.2%)	Prescription Drugs	457,156,653	438,830,340	(18,326,313)	(4.2%)
37,855,643	36,633,566	(1,222,077)	(3.3%)	MLTSS	384,375,912	370,265,907	(14,110,005)	(3.8%)
3,686,739	5,638,764	1,952,025	34.6%	Medical Management	36,471,769	48,326,263	11,854,493	24.5%
1,425,928	3,223,140	1,797,212	55.8%	Reinsurance & Other	212,858,970	32,049,480	(180,809,490)	(564.2%)
256,184,536	**254,842,361**	**(1,342,175)**	**(0.5%)**	**Total Medical Expenses**	**2,810,332,607**	**2,554,234,784**	**(256,097,823)**	**(10.0%)**
9,410,781	**13,398,431**	**(3,987,650)**	**(29.8%)**	**Gross Margin**	**117,157,271**	**133,483,702**	**(16,326,431)**	**(12.2%)**
				Administrative Expenses				
6,819,524	7,424,256	604,732	8.1%	Salaries, Wages & Employee Benefits	64,815,615	71,434,544	6,618,929	9.3%
278,612	418,322	139,710	33.4%	Professional Fees	2,051,940	3,823,442	1,771,502	46.3%
1,250,112	1,357,337	107,225	7.9%	Purchased Services	8,564,998	10,347,367	1,782,369	17.2%
495,407	398,237	(97,170)	(24.4%)	Printing and Postage	3,526,094	4,340,392	814,298	18.8%
520,335	455,750	(64,585)	(14.2%)	Depreciation & Amortization	3,526,697	4,557,500	1,030,803	22.6%
1,571,187	1,956,083	384,896	19.7%	Other Operating Expenses	14,758,317	16,787,526	2,029,209	12.1%
(231,842)	(183,112)	48,730	26.6%	Indirect Cost Allocation, Occupancy Expense	(2,591,992)	(1,774,749)	817,243	46.0%
10,703,335	**11,826,873**	**1,123,538**	**9.5%**	**Total Administrative Expenses**	**94,651,669**	**109,516,022**	**14,864,353**	**13.6%**
				Operating Tax				
11,551,474	11,131,538	419,936	3.8%	Tax Revenue	45,497,949	112,440,119	(66,942,170)	(59.5%)
11,083,333	11,131,538	48,205	0.4%	Premium Tax Expense	46,842,167	112,440,119	65,597,952	58.3%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
468,141	-	468,141	**0.0%**	**Total Net Operating Tax**	(1,344,218)	-	(1,344,218)	**0.0%**
				Grant Income				
68,512	-	68,512	0.0%	Grant Revenue	221,044	-	221,044	0.0%
53,550	-	(53,550)	0.0%	Grant expense - Service Partner	160,975	-	(160,975)	0.0%
5,687	-	(5,687)	0.0%	Grant expense - Administrative	98,543	-	(98,543)	0.0%
9,275	-	9,275	**0.0%**	**Total Grant Income**	(38,473)	-	(38,473)	**0.0%**
19	**-**	**19**	**0.0%**	**Other income**	**562**	**-**	**562**	**0.0%**
(815,119)	**1,571,558**	**(2,386,677)**	**(151.9%)**	**Change in Net Assets**	**21,123,472**	**23,967,680**	**(2,844,208)**	**(11.9%)**
96.5%	***95.0%***	***(1.5%)***	***(1.5%)***	***Medical Loss Ratio***	***96.0%***	***95.0%***	***(1.0%)***	***(1.0%)***
4.0%	***4.4%***	***0.4%***	***8.6%***	***Admin Loss Ratio***	***3.2%***	***4.1%***	***0.8%***	***20.7%***

MEDI-CAL INCOME STATEMENT – APRIL MONTH:

REVENUES of $265.6 million are unfavorable to budget $2.6 million driven by:

- Unfavorable volume related variance of $0.2 million
- Unfavorable price related variance of $2.4 million due to:
  - $6.7 million of LTC revenue from non-LTC categories of aid
  - $6.0 million of Coordinated Care Initiative (CCI) revenue
  - $3.6 million of Behavioral Health Treatment (BHT) revenue
  - Offset by $13.8 million of revenue from initial estimates of May Revise impact and updated rates from the Department of Health Care Services (DHCS)
  - $3.3 million of WCM revenue

MEDICAL EXPENSES of $256.2 million are unfavorable to budget $1.3 million driven by:

- Favorable volume related variance of $0.2 million
- Unfavorable price related variance of $1.5 million due to:
  - Prescription Drugs expense unfavorable variance of $7.5 million due to increased utilization
  - Professional Claims expense unfavorable variance of $3.4 million due to crossover claims
  - Provider Capitation expense unfavorable variance of $1.8 million
  - Facilities Claims expense favorable variance of $8.6 million due to decrease in claims Incurred But Not Reported (IBNR)
  - Medical Management expense favorable variance of $1.9 million
  - Reinsurance & Other expense favorable variance of $1.8 million

ADMINISTRATIVE EXPENSES of $10.7 million are favorable to budget $1.1 million driven by:

- Salaries & Benefit expense favorable to budget $0.6 million
- Other Non-Salary expense favorable to budget $0.5 million

CHANGE IN NET ASSETS is ($0.8) million for the month, unfavorable to budget $2.4 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Ten Months Ended April 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,151	**13,858**	**293**	**2.1%**	**Member Months**	**141,458**	**140,358**	**1,100**	**0.8%**
				Revenues				
2,652,396	2,715,129	(62,733)	(2.3%)	Medi-Cal Capitation Revenue	25,004,397	27,643,432	(2,639,035)	(9.5%)
27,082,365	16,429,412	10,652,953	64.8%	Medicare Capitation Revenue Part C	178,630,980	163,478,313	15,152,667	9.3%
6,009,097	4,796,622	1,212,475	25.3%	Medicare Capitation Revenue Part D	54,365,036	47,961,841	6,403,195	13.4%
-	-	-	0.0%	Other Income	-	-	-	0.0%
35,743,859	**23,941,163**	**11,802,696**	**49.3%**	**Total Operating Revenue**	**258,000,413**	**239,083,586**	**18,916,827**	**7.9%**
				Medical Expenses				
16,775,358	10,841,800	(5,933,558)	(54.7%)	Provider Capitation	117,469,405	109,186,664	(8,282,741)	(7.6%)
4,822,064	3,510,828	(1,311,236)	(37.3%)	Facilities Claims	38,363,282	35,069,860	(3,293,422)	(9.4%)
792,924	690,005	(102,919)	(14.9%)	Ancillary	7,597,447	6,860,645	(736,802)	(10.7%)
1,283,428	1,484,462	201,034	13.5%	MLTSS	13,363,945	15,355,618	1,991,673	13.0%
6,484,788	5,279,209	(1,205,579)	(22.8%)	Prescription Drugs	57,420,626	53,762,497	(3,658,129)	(6.8%)
1,662,106	1,185,578	(476,528)	(40.2%)	Medical Management	10,933,825	11,245,120	311,295	2.8%
112,359	222,541	110,182	49.5%	Other Medical Expenses	1,772,331	2,190,202	417,871	19.1%
31,933,027	**23,214,423**	**(8,718,604)**	**(37.6%)**	**Total Medical Expenses**	**246,920,862**	**233,670,606**	**(13,250,256)**	**(5.7%)**
3,810,832	**726,740**	**3,084,092**	**424.4%**	**Gross Margin**	**11,079,551**	**5,412,980**	**5,666,571**	**104.7%**
				Administrative Expenses				
775,814	868,216	92,402	10.6%	Salaries, Wages & Employee Benefits	7,225,803	8,290,255	1,064,452	12.8%
16,388	77,796	61,409	78.9%	Professional Fees	476,873	777,959	301,086	38.7%
90,338	142,989	52,651	36.8%	Purchased Services	1,354,776	2,029,887	675,111	33.3%
160,886	95,860	(65,026)	(67.8%)	Printing and Postage	705,378	958,603	253,225	26.4%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
38,228	71,888	33,660	46.8%	Other Operating Expenses	320,177	718,883	398,706	55.5%
552,199	519,792	(32,407)	(6.2%)	Indirect Cost Allocation	5,580,749	5,197,920	(382,829)	(7.4%)
1,633,854	**1,776,541**	**142,687**	**8.0%**	**Total Administrative Expenses**	**15,663,757**	**17,973,507**	**2,309,750**	**12.9%**
2,176,977	**(1,049,801)**	**3,226,778**	**307.4%**	**Change in Net Assets**	**(4,584,206)**	**(12,560,527)**	**7,976,321**	**63.5%**
89.3%	***97.0%***	***7.6%***	***7.9%***	***Medical Loss Ratio***	***95.7%***	***97.7%***	***2.0%***	***2.1%***
4.6%	***7.4%***	***2.8%***	***38.4%***	***Admin Loss Ratio***	***6.1%***	***7.5%***	***1.4%***	***19.2%***

ONECARE CONNECT INCOME STATEMENT– APRIL MONTH:

REVENUES of $35.7 million are favorable to budget $11.8 million driven by:

- Favorable volume related variance of $0.5 million
- Favorable price related variance of $11.3 million due to:
  - $6.8 million of revenue from calendar year (CY) 2019 Hierarchical Condition Category (HCC) reconciliation
  - $3.7 million of revenue from CY 2015 through 2018 estimated Centers for Medicare & Medicaid Services (CMS) HCC records adjustment

MEDICAL EXPENSES of $31.9 million are unfavorable to budget $8.7 million driven by:

- Unfavorable volume related variance of $0.5 million
- Unfavorable price related variance of $8.2 million due to:
  - Provider Capitation expense unfavorable variance of $5.7 million due to PY HCC reconciliation and records adjustment
  - Facilities Claims expense unfavorable variance of $1.2 million due to IBNR and shared risk pool
  - Prescription Drugs expense unfavorable variance of $1.1 million due to increased utilization

ADMINISTRATIVE EXPENSES of $1.6 million are favorable to budget $0.1 million

CHANGE IN NET ASSETS is $2.2 million, favorable to budget $3.2 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,364	**1,515**	**(151)**	**(10.0%)**	**Member Months**	**14,696**	**15,044**	**(348)**	**(2.3%)**
				Revenues				
(4,286,582)	1,115,200	(5,401,782)	(484.4%)	Medicare Part C revenue	6,634,357	11,181,658	(4,547,301)	(40.7%)
762,888	523,567	239,321	45.7%	Medicare Part D revenue	5,214,578	5,204,089	10,489	0.2%
(3,523,694)	**1,638,767**	**(5,162,461)**	**(315.0%)**	**Total Operating Revenue**	**11,848,935**	**16,385,747**	**(4,536,812)**	**(27.7%)**
				Medical Expenses				
(1,589,233)	431,942	2,021,175	467.9%	Provider Capitation	2,719,984	4,390,542	1,670,559	38.0%
230,958	499,369	268,411	53.7%	Inpatient	4,051,948	5,042,490	990,542	19.6%
40,434	54,580	14,146	25.9%	Ancillary	506,844	550,841	43,997	8.0%
70,265	44,821	(25,444)	(56.8%)	Skilled Nursing Facilities	230,645	452,478	221,833	49.0%
462,431	489,412	26,981	5.5%	Prescription Drugs	5,091,638	4,977,124	(114,514)	(2.3%)
82,781	49,151	(33,630)	(68.4%)	Medical Management	417,967	480,212	62,245	13.0%
-	10,934	10,934	100.0%	Other Medical Expenses	-	108,579	108,579	100.0%
(702,363)	**1,580,209**	**2,282,572**	**144.4%**	**Total Medical Expenses**	**13,019,026**	**16,002,266**	**2,983,240**	**18.6%**
(2,821,331)	**58,558**	**(2,879,889)**	**(4918.0%)**	**Gross Margin**	**(1,170,091)**	**383,481**	**(1,553,572)**	**(405.1%)**
				Administrative Expenses				
75,644	53,658	(21,986)	(41.0%)	Salaries, wages & employee benefits	671,254	517,570	(153,684)	(29.7%)
15,000	21,480	6,480	30.2%	Professional fees	189,371	214,800	25,429	11.8%
8,221	17,063	8,842	51.8%	Purchased services	127,949	170,630	42,681	25.0%
7,443	16,667	9,224	55.3%	Printing and postage	50,189	166,670	116,481	69.9%
235	4,738	4,503	95.0%	Other operating expenses	2,472	47,380	44,908	94.8%
37,170	35,589	(1,581)	(4.4%)	Indirect cost allocation, occupancy expense	384,976	355,890	(29,086)	(8.2%)
143,714	**149,195**	**5,481**	**3.7%**	**Total Administrative Expenses**	**1,426,212**	**1,472,940**	**46,728**	**3.2%**
(2,965,045)	**(90,637)**	**(2,874,408)**	**(3171.3%)**	**Change in Net Assets**	**(2,596,303)**	**(1,089,459)**	**(1,506,844)**	**(138.3%)**
19.9%	***96.4%***	***76.5%***	***79.3%***	***Medical Loss Ratio***	***109.9%***	***97.7%***	***(12.2%)***	***(12.5%)***
(4.1%)	***9.1%***	***13.2%***	***144.8%***	***Admin Loss Ratio***	***12.0%***	***9.0%***	***(3.0%)***	***(33.9%)***

CalOptima
PACE
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
403	**412**	**(9)**	**(2.2%)**	**Member Months**	**3,765**	**3,749**	**16**	**0.4%**
				Revenues				
2,677,129	2,475,666	201,463	8.1%	Medi-Cal Capitation Revenue	23,998,503	22,538,303	1,460,200	6.5%
462,629	562,149	(99,520)	(17.7%)	Medicare Part C Revenue	5,114,275	5,183,850	(69,575)	(1.3%)
304,601	152,270	152,331	100.0%	Medicare Part D Revenue	1,543,026	1,383,324	159,702	11.5%
3,444,359	**3,190,085**	**254,274**	**8.0%**	**Total Operating Revenue**	**30,655,803**	**29,105,477**	**1,550,326**	**5.3%**
				Medical Expenses				
792,670	911,081	118,411	13.0%	Medical Management	7,344,234	8,796,328	1,452,094	16.5%
713,203	609,302	(103,901)	(17.1%)	Facilities Claims	6,631,383	5,495,839	(1,135,544)	(20.7%)
655,933	652,622	(3,311)	(0.5%)	Professional Claims	5,720,504	6,006,539	286,035	4.8%
151,322	271,365	120,043	44.2%	Patient Transportation	2,024,172	2,424,428	400,256	16.5%
326,386	249,187	(77,199)	(31.0%)	Prescription Drugs	2,449,491	2,286,847	(162,644)	(7.1%)
14,365	40,490	26,125	64.5%	MLTSS	345,841	284,968	(60,873)	(21.4%)
5,038	6,667	1,630	24.4%	Other Expenses	201,272	66,667	(134,605)	(201.9%)
2,658,917	**2,740,714**	**81,797**	**3.0%**	**Total Medical Expenses**	**24,716,897**	**25,361,616**	**644,719**	**2.5%**
785,442	**449,371**	**336,071**	**74.8%**	**Gross Margin**	**5,938,906**	**3,743,861**	**2,195,045**	**58.6%**
				Administrative Expenses				
166,678	148,297	(18,381)	(12.4%)	Salaries, wages & employee benefits	1,428,944	1,431,675	2,731	0.2%
123	153	30	19.4%	Professional fees	1,629	1,530	(99)	(6.5%)
16,401	18,971	2,570	13.5%	Purchased services	87,928	189,710	101,782	53.7%
(4,350)	10,533	14,883	141.3%	Printing and postage	101,296	105,330	4,034	3.8%
2,126	2,116	(10)	(0.5%)	Depreciation & amortization	20,840	21,160	320	1.5%
4,267	4,135	(132)	(3.2%)	Other operating expenses	39,427	41,358	1,931	4.7%
4,221	4,304	83	1.9%	Indirect Cost Allocation, Occupancy Expense	42,970	40,788	(2,182)	(5.4%)
189,467	**188,509**	**(958)**	**(0.5%)**	**Total Administrative Expenses**	**1,723,035**	**1,831,551**	**108,516**	**5.9%**
				Operating Tax				
5,981	-	5,981	0.0%	Tax Revenue	23,640	-	23,640	0.0%
5,981	-	(5,981)	0.0%	Premium Tax Expense	23,640	-	(23,640)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
595,974	**260,862**	**335,112**	**128.5%**	**Change in Net Assets**	**4,215,871**	**1,912,310**	**2,303,561**	**120.5%**
77.2%	***85.9%***	***8.7%***	***10.1%***	***Medical Loss Ratio***	***80.6%***	***87.1%***	***6.5%***	***7.5%***
5.5%	***5.9%***	***0.4%***	***6.9%***	***Admin Loss Ratio***	***5.6%***	***6.3%***	***0.7%***	***10.7%***

CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 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				
46,927	23,101	(23,826)	(103.1%)	Purchase services	480,562	231,011	(249,551)	(108.0%)
196,483	174,725	(21,758)	(12.5%)	Depreciation & amortization	1,676,927	1,747,250	70,323	4.0%
18,423	15,866	(2,557)	(16.1%)	Insurance expense	175,711	158,660	(17,051)	(10.7%)
100,580	140,162	39,582	28.2%	Repair and maintenance	996,621	1,401,620	404,999	28.9%
31,488	46,432	14,944	32.2%	Other Operating Expense	409,803	464,320	54,517	11.7%
(393,900)	(400,286)	(6,386)	(1.6%)	Indirect allocation, Occupancy	(3,739,624)	(4,002,861)	(263,237)	(6.6%)
1	**-**	**(1)**	**0.0%**	**Total Administrative Expenses**	**0**	**-**	**(0)**	**0.0%**
(1)	**-**	**(1)**	**0.0%**	**Change in Net Assets**	**(0)**	**-**	**(0)**	**0.0%**

OTHER INCOME STATEMENTS – APRIL MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($3.0) million, unfavorable to budget $2.9 million due to CY 2015 through 2018 estimated CMS HCC records adjustment

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.6 million, favorable to budget $0.3 million

CalOptima
Balance Sheet
April 30, 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$377,294,987	Accounts Payable	$52,266,269
Investments	599,785,270	Medical Claims liability	772,950,933
Capitation receivable	418,197,504	Accrued Payroll Liabilities	15,448,856
Receivables - Other	37,451,464	Deferred Revenue	112,165,015
Prepaid expenses	7,902,477	Deferred Lease Obligations	170,710
		Capitation and Withholds	137,990,680
Total Current Assets	**1,440,631,702**	**Total Current Liabilities**	**1,090,992,463**
Capital Assets			
Furniture & Equipment	39,639,800		
Building/Leasehold Improvements	8,130,537		
505 City Parkway West	51,616,611		
	99,386,947		
Less: accumulated depreciation	(52,210,123)		
Capital assets, net	47,176,824	Other (than pensions) post employment benefits liability	25,928,611
Other Assets		Net Pension Liabilities	23,577,504
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,140,498,578**
Cash and Cash Equivalents	5,602,956		
Long-term Investments	575,096,270	Deferred Inflows	
Total Board-designated Assets	580,699,226	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	639,198,139	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,127,006,666**	TNE	101,413,430
		Funds in Excess of TNE	888,778,272
Deferred Outflows		**TOTAL NET POSITION**	990,191,702
Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,138,097,115**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,138,097,115**

CalOptima
Board Designated Reserve and TNE Analysis
as of April 30, 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	158,992,291				
	Tier 1 - MetLife	157,834,956				
	Tier 1 - Wells Capital	158,293,123				
Board-designated Reserve		475,120,371	324,555,816	507,114,064	150,564,555	(31,993,693)
TNE Requirement	Tier 2 - MetLife	105,578,855	101,413,430	101,413,430	4,165,426	4,165,426
	Consolidated:	**580,699,226**	**425,969,246**	**608,527,494**	**154,729,980**	**(27,828,268)**
	Current reserve level	*1.91*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
April 30, 2020

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	6,288,430	54,648,832
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	718,945	5,224,464
Changes in assets and liabilities:		
Prepaid expenses and other	(1,008,565)	(2,114,736)
Catastrophic reserves		
Capitation receivable	(16,856,270)	(103,707,202)
Medical claims liability	(8,934,669)	20,639,982
Deferred revenue	81,377,625	61,130,251
Payable to health networks	5,739,696	29,087,540
Accounts payable	10,513,618	9,599,543
Accrued payroll	1,606,888	5,640,434
Other accrued liabilities	-	126,198
Net cash provided by/(used in) operating activities	79,445,695	80,275,307
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	(81,329,581)	(26,078,973)
Change in Property and Equipment	156,678	(5,776,400)
Change in Board designated reserves	(3,876,618)	(20,553,818)
Change in Homeless Health Reserve	-	1,801,087
Net cash provided by/(used in) investing activities	(85,049,521)	(50,608,104)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(5,603,826)	29,667,203
CASH AND CASH EQUIVALENTS, beginning of period	$382,898,813	347,627,784
CASH AND CASH EQUIVALENTS, end of period	**377,294,987**	**377,294,987**

BALANCE SHEET – APRIL MONTH:

ASSETS of $2.1 billion increased $96.6 million from March or 4.7%

- Investments increased $81.3 million due to capitation received for Intergovernmental Transfers (IGT) 9
- Capitation Receivables increased $30.5 million due to timing of capitation received
- Receivables – Other decreased $13.7 million due to reclassification of sales tax overpayment in March
- Operating Cash decreased $5.6 million due to month end cut-off and the timing for cash flow requirements

LIABILITIES of $1.1 billion increased $90.3 million from March or 8.6%

- Deferred Revenue increased $81.4 million due to the reconciliation of IGT 9
- Accounts Payable increased $10.5 million due to the payment timing of sales tax
- Capitation and Withhold increased $5.7 million due to timing of Quality Incentive (QI) and shared risk payments
- Claims Liabilities decreased $8.9 million due to reclassification of sales tax overpayment in March

NET ASSETS total $990.2 million

Homeless Health Initiative and Allocated Funds
as of April 30, 2020

		Amount
Program Commitment		$100,000,000
Funds Allocation, approved initiatives:		
Be Well OC	$11,400,000	
Recuperative Care	8,500,000	
Housing Supportive Services	2,500,000	
Clinical Field Team Start-Up & Federal Qualified Health Center (FQHC)	1,600,000	
Homeless Response Team (CalOptima)	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Day & QI Program	1,231,087	
FQHC - Expansion	570,000	
Funds Allocation Total		41,801,087
Program Commitment Balance, available for new initiatives:		$58,198,913

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 April 2020

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	IS Application Development - Maintenance HW/SW (CalOptima Link Software)	IS Application Development - Maintenance HW/SW (Human Resources Corporate Application)	$32,700	Repurpose $32,700 from Maintenance HW/SW (CalOptima Link Software) to Maintenance HW/SW (Human Resources Corporate Application)	2020
July	Medi-Cal	IS Infrastructure - Capital Project (Server 2016 Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$38,300	Reallocate $38,300 from Capital Project (Server 2016 Upgrade) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	2020
July	Medi-Cal	IS Infrastructure - Capital Project (LAN Switch Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$25,700	Reallocate $25,700 from Capital Project (LAN Switch Upgrades) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	2020
December	Medi-Cal	IS Infrastructure - Maintenance HW/SW - Microsoft True-Up	IS Infrastructure - Maintenance HW/SW - Network Connectivity - Extreme Networks	$53,000	Repurpose $53,000 from Microsoft True-Up to Network Connectivity - Extreme Networks.	2020
December	Medi-Cal	Facilities - 6th Floor Lunchroom Remodel	Facilities - Replace Conference Room AV Equipment	$13,000	To reallocate $13,000 from Capital Projects 6th Floor Lunchroom Remodel and Conference Room 910 Upgrades to Capital Project Replace Conference Room AV Equipment.	2020
December	Medi-Cal	Facilities - Conference Room 910 Upgrades	Facilities - Replace Conference Room AV Equipment	$17,000	To reallocate $17,000 from Capital Projects 6th Floor Lunchroom Remodel and Conference Room 910 Upgrades to Capital Project Replace Conference Room AV Equipment.	2020
January	Medi-Cal	Member Survey - CG CAHPS	Inovalon Contract for HEDIS Software Training and Support hours	$40,000	To reallocate funds from Member Survey - CG CAHPS to Inovalon Contract for HEDIS Software Training and Support hours.	2020

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
June 4, 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 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

- Calendar Year (CY) 2018 Medicare Part D Prescription Drug Event Validation (OneCare and OneCare Connect):

  On January 10, 2020, CMS informed CalOptima that its OneCare and OneCare Connect programs have been selected to participate in the Calendar Year (CY) 2018 Medicare Part D Prescription Drug Event Validation (PEPV) audit.

  CMS conducts the audit to validate the accuracy of prescription drug event (PDE) data submitted by Medicare Part D sponsors for CY 2018 payments. CMS released the contract-specific documentation for both programs on January 24, 2020. CalOptima submitted supporting documentation for this audit on February 20, 2020. On February 25, 2020, CMS provided preliminary findings that the documentation has been accepted. No additional submissions are required at this time. CalOptima is awaiting CMS to provide the final findings report.

  On April 2, 2020, in light of the current public health crisis, CMS directed plans to cease making requests for documentation from providers regarding the CY 2018 PEPV audit. CMS will make an announcement when audit activities resume.

- CY2015 Medicare Part C Contract-level Risk Adjustment Data Validation (CON15 RADV) Audit:

  On November 21, 2019, CMS notified CalOptima that its OneCare program was selected to participate in the CY 2015 RADV audit. On January 10, 2020, CMS released the enrollee list and opened the submission window. CMS selected a total of thirty-three (33) members for this audit and requested the submission of medical record documentation by July 10, 2020.

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On March 30, 2020, in light of the current public health crisis, CMS suspended CY 2015 RADV audit activities and directed plans to cease making requests for documentation from providers immediately. CMS will make an announcement when audit activities resume. In the meantime, CMS will continue to review and provide feedback on medical records already submitted to CMS.

- Medicare Data Validation Audit (applicable to OneCare and OneCare Connect):

On an annual basis, CMS requires all plan sponsors to engage an independent auditor to conduct a Medicare Data Validation (MDV) audit of all Medicare Parts C and D data reported for the prior calendar year. A kick-off call with CalOptima's independent auditor, Advent, was held on January 6, 2020. Historically, the data validation audit season takes place from March through June each year. The audit includes a webinar validation and source documentation review of Medicare Parts C and D reporting data submitted for the prior calendar year.

On April 22, 2020, CalOptima participated in the 2020 Medicare Parts C and D Data Validation Audit, conducted by CMS' contractor, Advent Advisory Group ("Advent"). The following reporting measures were reviewed:

- Part C Special Needs Plans (SNPs) Care Management
- Part D Medication Therapy Management (MTM) Programs

On April 29, 2020, Advent provided CalOptima with sample selections for each of the required reporting measures and requested supporting documentation. CalOptima submitted the requested documents to Advent on May 19, 2020.

2. OneCare Connect

- National 2018 Risk Adjustment Data Validation (RADV) Audit:

On January 13, 2020, CMS informed CalOptima that its OneCare Connect program has been selected to participate in the CY 2018 Medicare Part C Improper Payment Measurement, known as the National Risk Adjustment Data Validation (RADV) audit. CMS will be conducting medical record reviews to validate the accuracy of the CY 2018 Medicare Part C risk adjustment data. The results of this review will be used to calculate a program-wide improper payment rate for Medicare Part C. On February 14, 2020, the CMS submission window opened and CalOptima was notified that only one (1) enrollee with three (3) hierarchical condition categories (HCCs) was selected for validation. The final deadline for submission of medical records to CMS is June 8, 2020. On March 23, 2020, CalOptima submitted medical records for all three (3) HCCs.

On April 13, 2020, CMS provided preliminary results, which indicated that the sampled HCCs were found within the medical records submitted and that no further action is required from CalOptima at this time. CalOptima is waiting for the final findings report.

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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3. Medi-Cal

- 2020 DHCS Medical Audit (Medi-Cal and OneCare Connect):

  The Department of Health Care Services' (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 February 12, the state notified CalOptima that, in response to a request from DHCS leadership, it planned to add to the Medi-Cal audit scope by reviewing authorization practices related to post-stabilization care. In addition to auditing CalOptima's practices, the DHCS indicated that it will also examine the practices of two (2) CalOptima delegates, Prospect Medical Group and Family Choice Medical Group.

  On April 24, the DHCS informed CalOptima that due to the recent COVID-19 health emergency, it would not be moving forward with the post-stabilization review. Instead, the DHCS will continue to finalize the findings report on the original scope. The DHCS stated that CalOptima can expect an exit conference in the coming weeks.

B. Regulatory Notices of Non-Compliance

CalOptima did not receive any notices of non-compliance from its regulators for the month of April 2020.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Auditing: Customer Service (OneCare, and OneCare Connect) [a\]

CalOptima's Audit & Oversight department performed an internal audit of CalOptima's Customer Service inquiries and oral grievances for the OneCare and OneCare Connect lines of business for the review period of October 1, 2019 through December 31, 2019. The audit areas included call log classification and oral grievances.

- OneCare Customer Service: Part C Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
October – December 2019	100%	100%	100%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- For the October – December 2019 file review of OneCare Part C inquiries, CalOptima's Customer Service department received a score of 100% on a focused audit of nine (9) inquiry calls selected for review.

- OneCare Customer Service: Part D Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
October – December 2019	100%	100%	100%

- For the October – December 2019 file review of OneCare Part D inquiries, CalOptima's Customer Service department received a score of 100% on a focused audit of nine (9) inquiry calls selected for review.

- OneCare Customer Service: Oral Grievances

Month	Misclassified Calls	File Review	Universe
October – December 2019	100%	100%	100%

- For the October – December 2019 file review of OneCare oral grievances, CalOptima's Customer Service department received a compliance score of 100% for a focused audit of nine (9) oral grievances selected for review and a score of 100% for timeliness based on the overall universe of oral grievances.

- OneCare Connect Customer Service: Part C Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
October – December 2019	100%	100%	100%

- For the October – December 2019 file review of OneCare Connect Part C inquiries, CalOptima's Customer Service department received a score of 100% based on a focused review of nine (9) inquiry calls 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 Customer Service: Part D Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
October – December 2019	100%	100%	100%

➢ For the October – December 2019 file review of OneCare Connect Part D inquiries, CalOptima's Customer Service department received a score of 100% based on a focused review of nine (9) inquiry calls selected for review.

- OneCare Connect Customer Service: Oral Grievances

Month	Misclassified Calls	File Review	Universe
October – December 2019	100%	100%	100%

➢ For the October – December 2019 file review of OneCare Connect oral grievances, CalOptima's Customer Service department received a score of 100% based on a focused review of nine (9) oral grievances selected for review and a score of 100% for timeliness based on the overall universe of oral grievances.

2. Health Network Monitoring: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified	Letter Score for Modified	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
December 2019	76%	84%	89%	72%	61%	86%	89%	68%	74%	83%	50%	53%	74%
January 2020	78%	84%	87%	90%	84%	86%	91%	82%	76%	87%	53%	74%	62%
February 2020	81%	83%	91%	85%	85%	90%	88%	71%	73%	80%	93%	86%	76%

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 select files, nine (9) health networks drove the lower compliance score for timeliness. Twenty-nine (29) of the ninety-nine (99) files received from the nine (9) 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 member notification (2 business days)
  - Failure to meet timeframe for provider initial notification (24 hours)
  - Failure to meet timeframe for provider written notification (2 business days)

- Based on a focused review of select files, seven (7) health networks drove the lower compliance score for clinical decision making (CDM). Sixty-two (62) of the ninety-one (91) files received from the seven (7) health networks were deficient. Deficiencies for the lower scores for CDM include the following:
  - Failure to have appropriate professional make decision
  - Failure to obtain adequate clinical information
  - Failure to cite criteria for decision

- Based on a focused review of select files, six (6) health networks drove the lower compliance letter score. Seventy (70) of the seventy-four (74) files received from the six (6) health networks were deficient. Deficiencies for the lower letter scores include the following:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide language assistance program (LAP) insert in approved threshold languages
  - Failure to provide member with information on how to file a grievance
  - Failure to provide letter in member's primary language
  - Failure to provide letter with description of services in lay language
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer
  - Failure to provide referral back to primary care provider (PCP) on denial letter
  - Failure to include name and contact information for health care professional responsible for the decision to deny or modify

- Based on the overall universe of Medi-Cal authorizations for January 2020, CalOptima's health networks received an aggregate compliance score of 99% for timely processing of routine authorization requests and a compliance score of 99% 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 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.

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- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
December 2019	98%	97%	99%	95%
January 2020	98%	99%	99%	95%
February 2020	100%	93%	98%	92%

- Based on a focused review of select files, the compliance score for paid claims accuracy decreased from 99% in January 2020 to 93% in February 2020 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by three (3) health networks with nine (9) files marked deficient for denied claim accuracy out of the twenty-seven (27) files received for February 2020.

- Based on a focused review of select files, the compliance score for denied claims timeliness decreased from 99% in January 2020 to 98% in February 2020 due to untimely processing of multiple claims. The lower score was driven by one (1) health network with five (5) files marked deficient for paid claims timeliness out of the twenty-four (24) files received for January 2020.

- Based on a focused review of select files, the compliance score for denied claims accuracy decreased from 95% in January 2020 to 92% in February 2020 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by four (4) health networks with sixteen (16) files marked deficient for denied claim accuracy out of the sixty-seven (67) files received for February 2020.

- Based on the overall universe of Medi-Cal claims for January 2020, CalOptima's health networks received an overall compliance score of 86% for timely processing of claims.

- 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 --- 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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3. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
December 2019	75%	100%	91%	87%	91%	100%	82%	88%
January 2020	100%	100%	97%	100%	94%	100%	96%	96%
February 2020	88%	100%	79%	100%	96%	100%	96%	96%

- Based on a focused review of select files, one (1) health network drove the lower compliance score for timeliness with four (4) of the eight (8) files marked as 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)

- Based on a focused review of select files, one (1) health network drove the lower compliance letter score with all eight (8) files received marked as deficient. Deficiencies for the lower letter scores include the following:
  - Failure to use approved CalOptima logo
  - Failure to use approved CMS template
  - Failure to provide letter with description of services in lay language

- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for January 2020, CalOptima's health networks received an overall compliance score 82% for timely processing of standard Part C authorization requests and 72% 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 ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

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- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
December 2019	100%	100%	100%	98%
January 2020	99%	100%	99%	99%
February 2020	94%	94%	100%	96%

- Based on a focused review of select files, the compliance score for paid claims timeliness decreased from 99% in January 2020 to 94% in February 2020 due to untimely processing of multiple claims. The lower score was driven by one (1) health network with three (3) out of five (5) files marked deficient for paid claim timeliness for February 2020.

- Based on a focused review of select files, the compliance score for paid claims accuracy decreased from 100% in January 2020 to 94% in February 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 three (3) of the five (5) files received marked as deficient for February 2020.

- Based on a focused review of select files, the compliance score for denied claims accuracy decreased from 99% in January 2020 to 96% in February 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 four (4) of the eight (8) files received marked as deficient for February 2020.

- Based on the overall universe of OneCare claims for CalOptima's health networks for January 2020, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
  - 86% for non-contracted clean claims paid or denied within 30 calendar days of receipt.
  - 92% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 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 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 --- staff training, process development, system enhancements, ongoing inline

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monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

4. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
December 2019	95%	100%	89%	91%	84%	68%	87%	85%	100%	100%	100%
January 2020	95%	100%	92%	96%	94%	65%	86%	91%	100%	84%	79%
February 2020	96%	100%	91%	97%	94%	98%	77%	96%	50%	50%	50%

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for timeliness. All two (2) files received from the two (2) health networks were deficient. Deficiencies for the lower scores for timeliness include the following:
  - Failure to submit appropriate file selection

- Based on a focused review of select files, four (4) health network drove the lower compliance score for clinical decision making (CDM). Thirteen (13) of the fourteen (14) files received from the health networks were deficient. Deficiencies for the lower scores for CDM include the following:
  - Failure to cite criteria for decision

- Based on a focused review of select files, five (5) health network drove the lower compliance letter score. Sixteen (16) of the thirty-three (33) files received from the five (5) health networks were deficient. Deficiencies for the lower letter scores include 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

- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for January 2020, CalOptima's health networks received an overall compliance score of 99% for timely processing of routine authorization requests and 99% 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 network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process

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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
December 2019	95%	99%	99%	98%
January 2020	90%	99%	99%	95%
February 2020	97%	93%	99%	95%

- Based on a focused review of select files, the compliance score for paid claims accuracy decreased from 99% in January 2020 to 93% in February 2020 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by three (3) health networks with seven (7) of the twenty-six (26) files received for February 2020 marked as deficient.

- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for January 2020, CalOptima's health networks received the following overall compliance scores:
  - 88% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  - 89% for non-contracted and contracted unclean claims paid or denied within 45 calendar days of receipt
  - 90% 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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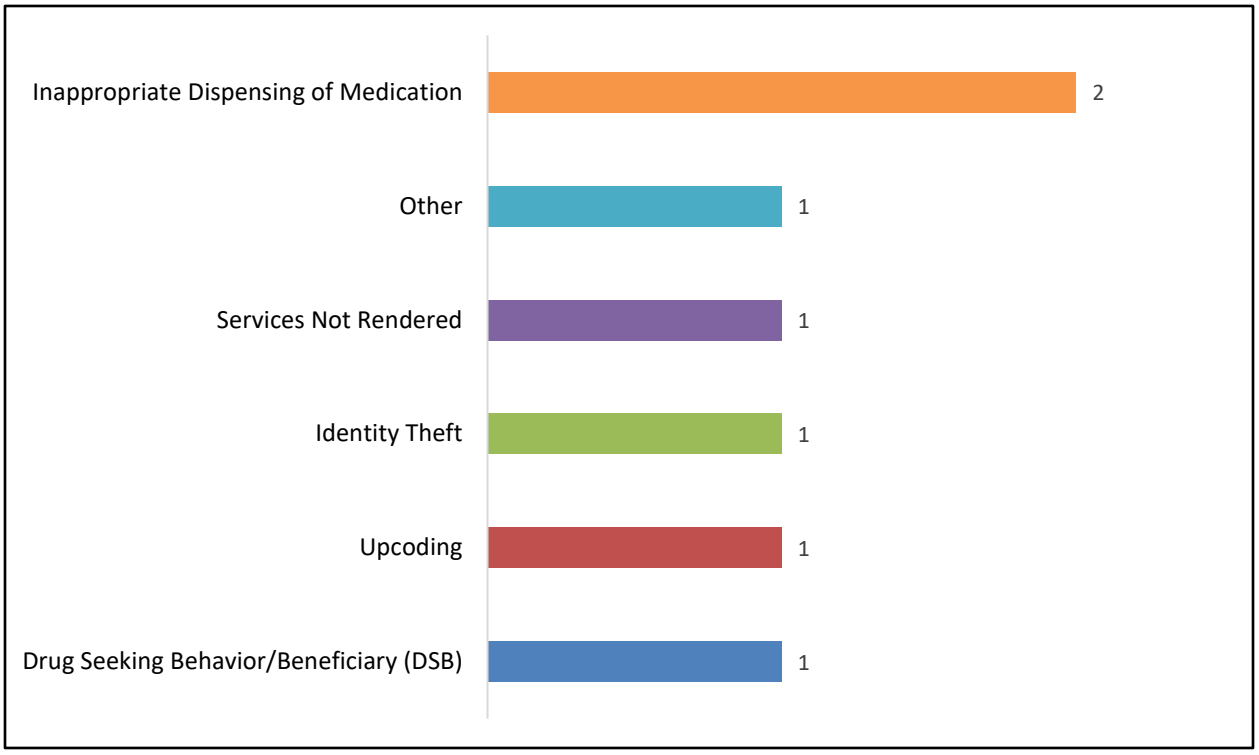
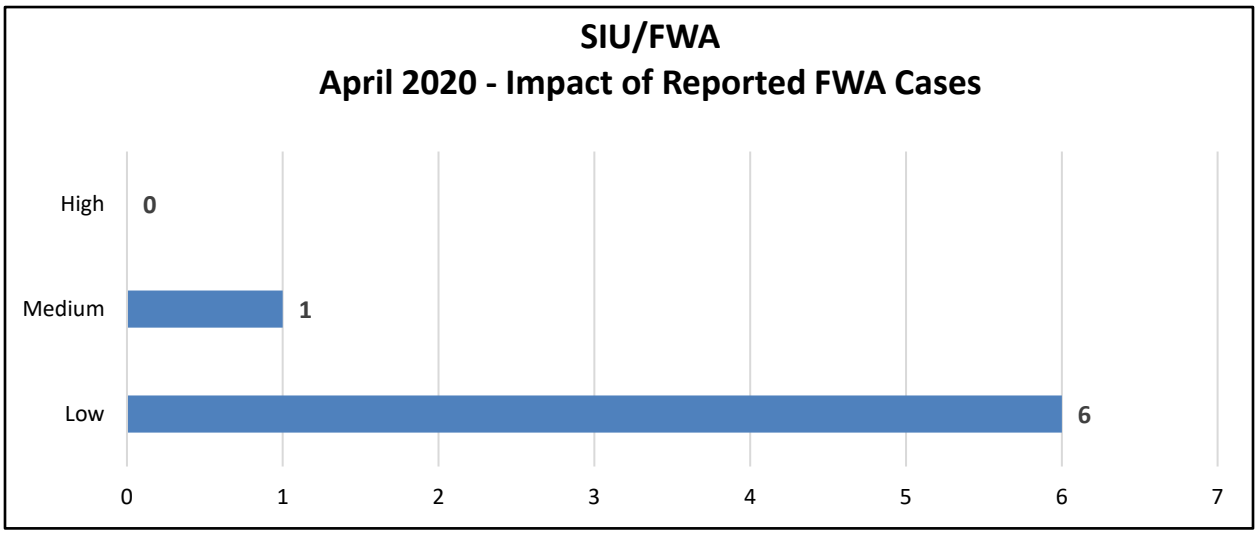
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in April 2020)





Total Number of Referrals Reported to DHCS (State)	7
Total Number of Referrals / Fraud Cases Reported to DHCS and MEDIC	0
Total Number of Referrals Reported	**7**

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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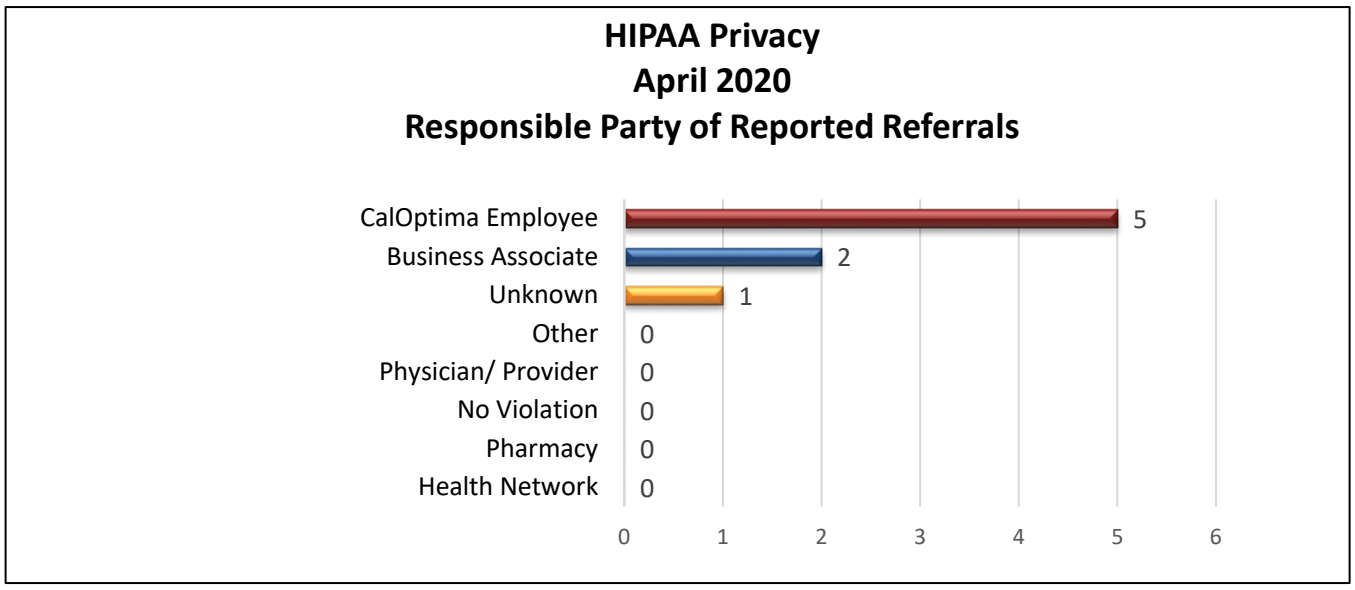
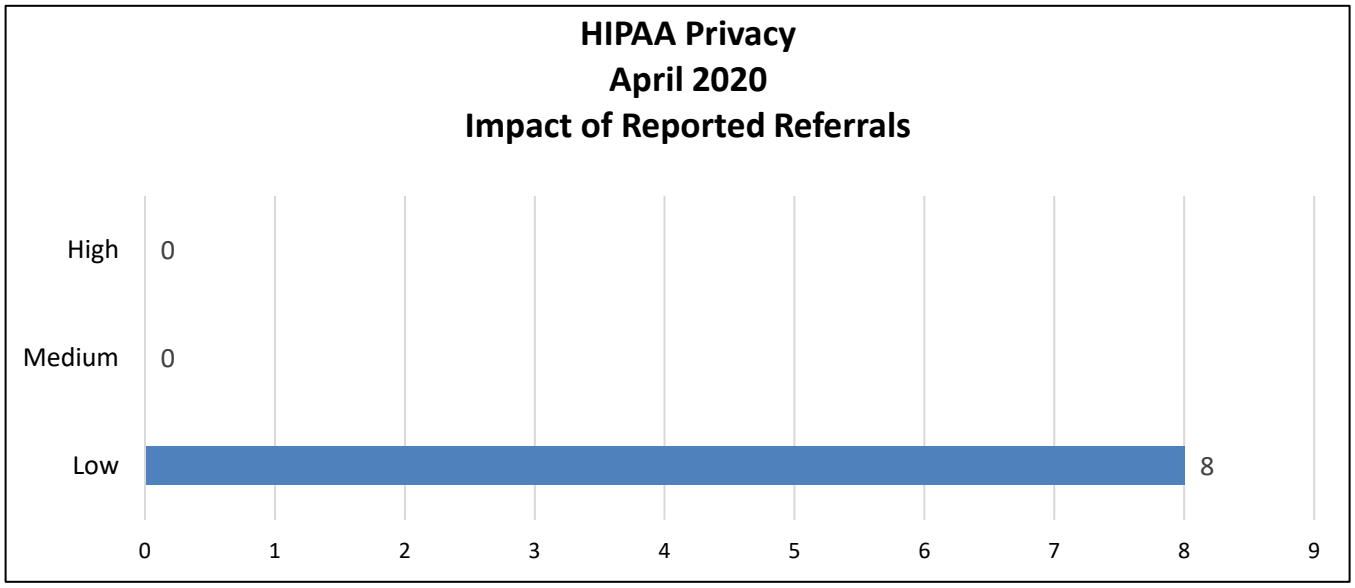
E. Privacy Update: (April 2020)





Total Number of Referrals Reported to DHCS (State)	8
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**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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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

May 11, 2020

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: May Board of Directors Report

Following passage of an interim funding measure late last month, Congress is set to take up the next COVID-19 response package as soon as this week. While the number of new cases nationwide appears to be levelling off, the economy continues to reel from the pandemic and many lawmakers have signaled that further legislative action will be needed. This report covers developments through May 11, 2020.

Phase 3.5 Passage
Funds for the Small Business Administration's (SBA's) Paycheck Protection Program (PPP) were exhausted in just 13 days following enactment of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136), leaving hundreds of thousands of small businesses shut out of the program. In response, Congress quickly took up a "Phase 3.5" measure to replenish the small business loan program and funding for health care providers. The Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139), signed into law on April 24, added:

- $310 billion in funding for the PPP;
- $75 billion for the provider relief fund managed by the Department of Health and Human Services (HHS); and
- $25 billion to research, develop, validate, manufacture, purchase, administer, and expand capacity for COVID-19 tests.

Of the additional $310 billion for the PPP, $60 billion is to be provided through small and medium-sized lenders to serve otherwise underserved small businesses. SBA subsequently announced that it would restrict applications to only those from with less than $1 billion in assets. As funding dwindles, SBA is expected to impose stricter requirements on the loans. More than half of the new funding has already been exhausted, and there are growing calls from the business community for yet another infusion of funds.

Phase 4 Outlook
House Speaker Nancy Pelosi (D-CA) has solicited feedback from committee chairs and caucuses on legislative priorities to include in a "Phase 4" COVID-19 response package, with the goal of finalizing a bill the week of May 11. Democratic priorities for the package include:

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- Additional relief for state and local governments;
- Extension of enhanced unemployment benefits;
- Expanded food assistance;
- Additional provider relief funding;
- Hazard pay for front line workers;
- Student loan assistance;
- Consolidated Omnibus Budget Reconciliation Act (COBRA) subsidies;
- Enhanced Medicaid funding for states; and
- Funding for a national COVID-19 testing program.

Some House Democrats are also pushing for several proposals to help undocumented immigrants, such as providing emergency Medicaid coverage for COVID-19 testing and treatment, halting enforcement of the Administration's "public charge" rule, and extending expiring work authorizations.

Senate Republicans, meanwhile, have suggested that Congress wait before passing another large and expensive stimulus bill. Republican Leadership have suggested that the next legislative response focus on liability reform and expanding immunity for health care providers, employers, and others responding to the pandemic. The House could reconvene as early as May 15 for votes on a Phase 4 package, though negotiations with the Senate are likely to drag on throughout May. House Democrats also plan to vote on a bill to allow proxy voting in certain circumstances and allow committees to conduct all business remotely, including markups.

Committee Action
The Senate reconvened on May 4 and soon commenced hearings on the COVID-19 outbreak. On May 7, Francis Collins, Director of the National Institutes of Health (NIH), and Gary Disbrow, Acting Director of the Biomedical Advanced Research and Development Authority (BARDA), testified before the Senate Health, Education, Labor and Pensions (HELP) Committee on diagnostics for COVID-19. The witnesses spoke in particular about the importance of rapid, point-of-care tests and stated that broad testing capacity and contact tracing will be needed to safely reopen the country. The HELP Committee will hold another hearing on May 12 to examine how to safely reopen schools and workplaces. Several of the witnesses – including Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases (NIAID), Robert Redfield, Director of the Centers for Disease Control and Prevention (CDC), and Stephen Hahn, Commissioner of the FDA – will testify via video conference following their possible exposure to the virus.

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The House Labor-HHS Appropriations Subcommittee held a hearing on the COVID-19 outbreak on May 6. Former CDC Director Tom Frieden and Johns Hopkins professor Caitlin Rivers testified on the public health response to the pandemic.

On April 23, the House voted along party lines to form the Select Subcommittee on the Coronavirus Crisis within the House Oversight and Reform Committee. The subcommittee, led by Majority Whip Rep. Jim Clyburn (D-SC), is tasked with overseeing the Trump Administration's implementation of COVID-19 relief efforts. Republicans opposed the creation of the subcommittee, accusing Democrats of using the panel to damage the President politically ahead of the November elections.

Provider Relief Fund Update
The CARES Act included $100 billion for HHS' Provider Relief Fund, and the Phase 3.5 bill added an additional $75 billion to this fund. To date, $50 billion has been allocated for general distribution to Medicare facilities and providers based on 2018 net patient revenue. These payments were distributed in several tranches in April. Providers who receive the funds must attest to receipt of the payments via an online portal and agree to the Terms and Conditions which, among other provisions, prohibit balance billing for patients with actual or presumptive COVID-19 infections.

On May 1, HHS also began distributing $12 billion to hospitals in COVID-19 "hotspots." The funds are going to 395 hospitals who provided inpatient care for 100 or more COVID-19 patients through April 10. An unspecified portion of the Provider Relief Fund will be used to reimburse health care providers, at Medicare rates, for COVID-related treatment of the uninsured. Another $10 billion has been allocated for rural health clinics and hospitals.

According to HHS, some providers – including dentists, skilled nursing facilities, and Medicaid-only providers – will receive additional separate funding. HHS has asked states to provide information regarding Medicaid payments to individual providers to inform an upcoming disbursement from the fund. Congressional Democrats are calling for greater transparency regarding these allotments, their timing, and the formula used to allocate the funds.

ACA Case
California's opening brief in *Texas v. United States* was due May 6 under the extended briefing schedule approved last month by the Supreme Court. Texas and the Administration will file their briefs on June 25. Attorney General William Barr reportedly had been pushing the Administration to pull back from its argument that the entire Affordable Care Act (ACA) should be struck down, contending instead that parts of the law could be preserved. However, it appears that the Department of Justice will retain its position that the individual mandate is not severable

from the remainder of the law, which should be invalidated in its entirety if the mandate is found to be unconstitutional.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

May 8, 2020

COVID-19 UPDATE
Edelstein Gilbert Robson & Smith LLC

This week, Governor Newsom announced the beginning of a gradual reopening of the economy. As of today, California is moving into the early stages of "phase 2." This means the reopening of retail locations for curbside pickup as well as the associated manufacturing and logistics needed for this supply chain. As we reported earlier this week, the Governor also signed an executive order creating a rebuttable presumption that victims of COVID-19 that worked 14 days before testing positive would be eligible for workers' compensation benefits.

Continuing to stress the need to let local public health officers find the best path forward, the Governor will be issuing guidance next week laying out the criteria counties must meet to lift more restrictions within the narrow scope of phase 2 ahead of the state.

As we have reported previously, the Governor has enjoyed an outpouring of public trust and support since the beginning of the crisis. Nevertheless, with Californians settling into their new routines and the initial panic of the pandemic wearing off, the Governor is facing more scrutiny and public frustration with some of his actions.

Since mid-March, 4.2 million Californians have had to file for unemployment due to the state's shelter in place order. Given the large volume of new applicants, Governor Newsom has increased staffing at unemployment call centers and increased call center hours. He has touted the fact that despite the large volume of new claims the state has maintained its Pre-COVID three-week turnaround on unemployment claims. Nevertheless, those filing for unemployment benefits have complained of extremely long wait times on the phone, dropped calls, online errors, frozen screens, and delays in processing supplemental benefits for gig workers and the self-employed. These issues have become a consistent thorn in the Governor's side as he continues to be questioned on them during press conferences and at legislative oversight hearings.

The Governor's procurement of personal protective equipment (PPE) has become an even bigger problem. We have previously discussed the $1 billion deal the Governor struck in early April to procure PPE from BYD. BYD has some history of providing faulty equipment and the Governor's refusal to provide the Legislature and the public with the $1 billion contract has been criticized. This week, CalMatters broke a story revealing that in late March the state struck a $456.9 million deal with a PPE company, Blue Flame. Blue Flame had formed only three days prior to its deal with California. Hours after wiring money to Blue Flame, the state chose to cancel the contract and claw back the money. The Governor's Office has offered little explanation for this but has emphasized that the state got its money back and learned from the experience. The FBI has announced that it will be investigating Blue Flame and is focusing on the deals

it struck with California and Maryland. With the revelations about the Blue Flame deal, the Governor released the BYD contract to the Legislature and the public.

Budget

The Governor's Department of Finance (DOF) has revealed that California is facing a massive $54.3 billion deficit. This unprecedented deficit represents a 37% drop from the General Fund spending in the 2019-2020 budget. While this is roughly proportional to the deficits the state experience during the last two recessions, the total dollar amount is much higher.

The deficit is being driven by two factors. Revenue from income taxes, corporate taxes, and sales and use taxes have all fallen by around 25%. At the same time, enrollment in social safety net programs have resulted in $7.1 billion of unanticipated costs to the state. In addition, the Governor has had to spend $6 billion responding to the COVID-19 crisis.

While the state has a reserve of roughly $20 billion, the Legislature and the Governor will be facing a number of difficult choices in the 2020-2021 budget. The minimum guarantee for K-12 schools and community colleges will fall by around $18 billion. To avoid making these cuts, however, the state would have to find ways of cutting funding to social safety net programs or increasing revenue by imposing new taxes.

The Governor and most of the Legislature have never had to address a budget deficit of this size. The state made its way out of the 2008 recession by slashing Medi-Cal benefits and reducing funding to the courts and the state's CSU and UC systems. At the same time, then Governor Brown successfully convinced voters to impose higher taxes on the top 1% of income earners in the state. These are the types of solutions that will be necessary to balance the budget in the coming years.

These will be tough choices for an ambitious and politically astute politician like Governor Newsom. As a progressive Democrat, cutting social safety net funding could be fodder for future Democratic rivals. At the same time, raising taxes at a time when the state is reeling from the worst recession since the Great Depression is both challenging and dangerous.

Next week the Governor will release his May Revision to the budget. We expect that it will defer major decisions to August when the state will have a more concrete sense of both revenue and costs. However, it may shed more light on the details of the state's budget woes.

We will keep you apprised of further developments.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

May 15, 2020

BUDGET UPDATE: GOVERNOR'S MAY REVISION
Edelstein Gilbert Robson & Smith LLC

Yesterday Governor Newsom released his May Revision to his January Budget. In a normal year, the May Revision is a chance for the Governor to fine tune his January proposal based on more up to date revenue estimates for the coming year.

In 2020, the May Revision is all about responding to the economic crisis caused by COVID-19. Between January and May, the state has seen a 22.3% decline in revenue and 4.6 million new unemployment claims filed since mid-March. This drop in revenue combined with higher caseloads for social safety net programs has eviscerated the multi-billion-dollar surplus the Governor anticipated in January.

All of this has led the Legislative Analyst's Office (LAO), a non-partisan advisor to the Legislature, to estimate anywhere from an $18 to $31 billion deficit. The Governor's Department of Finance (DOF), is projecting a higher deficit of $54.3 billion for two reasons. First, the Governor has chosen to calculate the deficit based on his *proposed* expenditures in the January Budget rather than the expenses the state is obligated to pay under current law. Second, the Department of Finance is projecting a $13 billion increase in caseload for social safety net programs and other expenses related to COVID-19.

The Governor's May Revision would resolve the projected $54.3 billion deficit with the following solutions:

- 16% from the state's reserves
- 15% from the federal government under the CARES Act
- 15% from cancelling proposals for additional spending from the January budget
- 19% from internal borrowing from special funds
- 26% "triggered cuts" as described below
- 8% from revenue gained by limiting the use of net operating losses and tax credits

Medi-Cal

The Governor's May Revise estimate an additional two million Medi-Cal enrollees compared to estimates prior to COVID-19.

Not surprisingly, the May Revise proposes several cuts in the current Medi-Cal program as well as eliminating some of the proposes put forth in the Governor's January budget proposal.

The May Revise eliminates the following proposals:

- California Advancing and Inovating Medi-Cal (CalAIM)

- Full-Scale Medi-Cal for Undoumented Older Adult
- Medi-Cal Aged, Blind, and Disabled Income Level Expansion
- 340B Supplemental Payment Pool
- Postpartum Mental Health Expansion
- Hearing Aids

In addition, the May Revise proposes reducing adult dental to the partial restoration levels of 2014. The Governor also proposes to eliminate various optional benefits, including audiology, incontinence creams and washes, speech therapy, optician/optical lab, podiatry, acupuncture, optometry, nurse anesthetists services, occupational and physical therapy, pharmacist services, screening, brief intervention and referral to treatments for opioids and illicit drugs in Medi-Cal, and diabetes prevention program services .

Other significant proposals in the May Revision include changes to the way that managed care capitation rates are determined. These changes include various acuity, efficiency, and cost containment adjustments. These adjustments would be effective for the managed care rate year starting January 1, 2021.

We have several general observations about the May Revise.

May Revise Spreads the Use of Reserves Across Several Budget Years
The state has $16.2 billion in its “Rainy Day Fund” and several billion more in additional reserves including social safety net and Proposition 98 (school funding) reserves. Collectively, the Governor is planning to use only $8.8 billion of our reserves in the current budget year. The Governor is proposing to use the remainder of the state’s reserves to bridge gaps in the next two budget years.

May Revise Relies on Several One Time Solutions
The use of state reserves, one-time appropriations from the federal government, and borrowing from state special funds are all one-time solutions. This means that in future budget years California will still be confronting a significant structural deficit as revenues continue to fall below expenses. The size of this ongoing deficit will depend on the strength of the economy. The May Revise projects that this deficit could be higher than $16 billion in future budget years.

Federal Funding or Cuts
The biggest solution proposed by the Governor involves cuts to funding that will be triggered if the federal government does not provide funding to states before the new fiscal year starts on July 1. During his press conference yesterday, Governor Newsom appealed directly to President Trump to support Speaker Pelosi’s “HEROES Act.” The $3 trillion stimulus proposal would fill in multi-billion-dollar gaps in the state’s budget.

If the “HEROES Act” or other federal support is not forthcoming, the May Revise includes billions of triggered cuts. The brunt of these cuts, $6.5 billion, fall on K-12 funding. More than a billion in additional cuts would come to UC’s, CSU’s, and the

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state's community college system. Collectively billions more are proposed for social safety net programs, state parks, and court systems. Finally, the Governor has proposed a 10% pay cut for state employees if federal relief is not forthcoming. This cut would result in $2.8 billion in savings.

The trigger cuts in the May Revise could quickly become a thorny issue for the Governor and the Legislature. If federal relief does not materialize to stop all or some of these cuts, they will have to choose whether they let the cuts happen, or attempt to avoid them by imposing new taxes or spending reserves faster than the Governor plans to. Some progressive Democrats in the Legislature have already balked at the prospect of the cuts which hit programs that are very important to their core constituencies. If the federal government does not intervene to provide funding, the Governor and the Legislature would have a very short window of time between the beginning of July and the end of August to find alternatives to avoid the cuts. Unless those alternatives included long term solutions, the budget would experience larger structural issues in the coming years.

The Legislature will now have just one month to weigh in and to negotiate with the Governor as the constitution requires the passage of a balanced budget by June 15. With tax filing deadlines delayed, the state will not have a complete picture of revenue shortfalls until after July 15. Given that, it is likely that the Legislature and Governor will revisit the budget in July and August.

We will keep you apprised of further developments.

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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
AB 89 Ting	**Emergency Budget Response to COVID-19:** Similar to SB 89, would appropriate $500 million General Fund by amending the Budget Act of 2019. Funds are to be allocated to any use related to Governor Newsom's March 4, 2020 State of Emergency regarding COVID-19. Additionally, would authorize 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.	**03/16/2020** Amended and referred to the Senate Committee on Budget and Fiscal Review **12/03/2018** Introduced	CalOptima: Watch
AB 117 Ting	**Emergency Budget Response to COVID-19 at Schools:** Similar to SB 117, appropriate $100 million Proposition 98 General Fund to ensure schools are able to purchase protective equipment or supplies for cleaning school sites. Funds would be distributed by the Superintendent of Public Instruction.	**03/16/2020** Amended and referred to the Senate Committee on Budget and Fiscal Review **12/03/2018** Introduced	CalOptima: Watch
SB 89 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19:** Similar to AB 89, appropriates $500 million General Fund by amending the Budget Act of 2019. Funds will be allocated to any use related to Governor Newsom's March 4, 2020 State of Emergency regarding COVID-19. Additionally, authorizes additional appropriations related to COVID-19 in increments of $50 million, effective 72 hours following notification of the Director of Finance. Of note, the total amount appropriated to COVID-19 is not to exceed $1 billion.	**03/17/2020** Signed into law **03/16/2020** Enrolled with the Governor **01/10/2019** Introduced	CalOptima: Watch
SB 117 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19 at Schools:** Similar to AB 117, appropriates $100 million Proposition 98 General Fund to ensure schools are able to purchase protective equipment or supplies for cleaning school sites. Funds will be distributed by the Superintendent of Public Instruction.	**03/17/2020** Signed into law **03/16/2020** Enrolled with the Governor **01/10/2019** Introduced	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 910 Wood	**Mental Health Services Dispute Resolution:** Would provide the Department of Health Care Services (DHCS) more authority to resolve coverage disputes between the specialty mental health plan (MHP) and the Medi-Cal managed care plan (MCP) if the MHP and the MCP are unable to do so within 15 days. Would require the MHP and the MCP to continue to provide mental health services during the DHCS review period. DHCS would have no more than 30 days to resolve the dispute to determine which agency is responsible for that Medi-Cal beneficiary.	**01/30/2020** Passed Assembly floor; Referred to Senate floor **02/20/2020** Introduced	CalOptima: Watch
AB 2265 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Similar to AB 2266, would authorize MHSA funds to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The authorization would apply across the state. Additionally, would require the county that elects to utilize MHSA funding for this purpose to report outcomes achieved to the Department of Health Care Services.	**05/05/2020** Re-referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2266 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Similar to AB 2265, would authorize MHSA funds to be used for a pilot program to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The pilot program would take place in 10 counties, including the County of Orange, beginning January 1, 2022 and ending on December 31, 2026.	**02/24/2020** Referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2576 Gloria	Mental Health Services Act (MHSA) Use of Funds for Homelessness: Would require counties utilizing MHSA funds for the provision of mental health services for those experiencing homelessness to report to the Legislature, each year, the number of individuals receiving services.	**05/05/2020** Re-referred to Committee on Health **02/20/2020** Introduced	CalOptima: Watch
SB 803 Beall	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Would create the Certified Support Specialist (CSS) certificate program. Would allow parents, peers, and family, 18 years of age or older and who have experienced a mental illness and/or a substance use disorder, to become a CSS. A CSS would be able to provide non-medical mental health and substance abuse support services. Additionally, would require the Department of Health Care Services to include CSS as a provider type, covered by Medi-Cal, no sooner than January 1, 2022. If federally approved, the peer-support program would be funded through Medi-Cal reimbursement.	**05/13/2020** Passed Committee on Health; Referred to Committee on Appropriations **01/08/2020** Introduced	CalOptima: Watch
SB 1254 Moorlach	**Capacity Determinations and Appointments of Guardians Ad Litem for Mentally Ill Adults Without a Conservator:** Would establish an additional procedure for the appointment of a guardian ad litem for a person who lacks the capacity to make rational informed decisions regarding medical care, mental health care, safety, hygiene, shelter, food, or clothing with a rational thought process due to a mental illness, defect, or deficiency. The bill would authorize certain persons to petition the court for the appointment of a guardian ad litem under these provisions.	**05/22/2020** Hearing canceled at the request of the author. **05/11/2020** Referred to Committee on Judiciary **02/21/2020** Introduced	CalOptima: Watch

BLOOD LEAD SCREENINGS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2276 Reyes	**Blood Lead Screening Tests Age Guidelines:** Would require the Medi-Cal managed care plan (MCP) to conduct blood lead screening tests for a Medi-Cal beneficiary at 12 and 24 months of age. This would require the MCP to contract with providers qualified to conduct any blood level screening tests and for the MCP to notify the beneficiary's parent or guardian that the beneficiary is eligible for blood lead screening tests. Additionally, if a child two to six years of age does not have medical records stating the completion of a blood lead screening test, the MCP would be required to provide at least one blood lead screening test. The MCP would also be required to report to the Department of Health Care Services (DHCS) the number of beneficiaries aged one and two who have received a blood lead screening test and of any associated case management services provided.	**05/12/2020** Re-referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2277 Salas	**Blood Lead Screening Tests Contracted Providers:** Would require the Medi-Cal managed care plan (MCP) to identify beneficiaries who have missed a blood screening test at both 12 and 24 months of age and impose requirements of the contracted provider to conduct blood lead screenings tests for those eligible to receive such tests. Would require the MCP to remind the contracted provider to conduct blood lead screening tests and to notify the beneficiary's parent, parents, guardian, or other person responsible for their care that the beneficiary is eligible to receive a blood screening test.	**05/05/2020** Re-referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2278 Quirk	**Childhood Lead Poisoning Prevention Health Plan Identification:** Would require the name of the health plan financially liable for conducting blood lead screenings tests to be reported by the laboratory to the Department of Health Care Services once the screening test has been completed. The name of the health plan is to be reported for each Medi-Cal beneficiary who receives the blood lead screen tests.	**02/24/2020** Referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2279 Garcia	**Childhood Lead Poisoning Prevention Risk Factors:** Would require the following risk factors be included in the standard risk factors guide, which are to be considered during each beneficiary's periodic health assessment: ■ A child's residency or visit to a foreign country ■ A child's residency in a high-risk ZIP Code ■ A child's relative who has been exposed to lead poisoning ■ The likelihood of a child placing nonfood items in the mouth ■ A child's proximity to current or former lead-producing facilities ■ The likelihood of a child using food, medicine, or dishes from other countries	**05/13/2020** Re-referred to Committees on Health; Environmental Safety and Toxic Materials **02/14/2020** Introduced	CalOptima: Watch
AB 2422 Grayson	**Blood Lead Screening Tests Medi-Cal Identification Number:** Would require the Medi-Cal identification number to be added to the list of patient identification information collected during each blood test. Would require the laboratory conducting the blood lead screening tests to report all patient identification information to the Department of Health Care Services.	**02/27/2020** Referred to Committee on Health **02/19/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 1008 Leyva	**Childhood Lead Poisoning Prevention Act Online Registry:** Would require the Department of Public Health to design, implement, and maintain an online lead information registry available to the general public. Would require the information registry to include items such as the location and status of properties being inspected for lead contaminants.	**03/05/2020** Referred to Committees on Health; Judiciary **02/14/2020** Introduced	CalOptima: Watch

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2042 Wood	**CalAIM Enhanced Care Management and In-Lieu-Of Services:** Similar to SB 916, would require enhanced care management as a covered benefit for Medi-Cal beneficiaries, including the coordination of all primary, acute, behavioral, oral, and long-term services and supports. Additionally, would require the Medi-Cal managed care plan to include a variety of in-lieu-of services as an optional benefit for beneficiaries posted on their website and in the beneficiary handbook.	**03/12/2020** Referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch
AB 2055 Wood	**CalAIM Drug Medi-Cal and Behavioral Health:** Would require the Department of Health Care Services to establish the Behavioral Health Quality Improvement Program. The Behavioral Health Quality Improvement Program would be responsible for providing support to entities managing the Drug Medi-Cal program as they prepare for any changes directed by the CalAIM initiative. Additionally, would establish a voluntary intergovernmental transfer (IGT) program relating to substance use disorder treatment provided by counties under the Drug Medi-Cal program. The IGT program would fund the nonfederal share of supplemental payments and to replace claims based on certified public expenditures.	**03/12/2020** Referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch
AB 2170 Blanco Rubio	**CalAIM Medi-Cal Eligibility for Juveniles Who are Incarcerated:** Would require the county welfare department to conduct a redetermination of eligibility for juveniles who are incarcerated so that, if eligible, their Medi-Cal would be reinstated immediately upon release.	**02/20/2020** Referred to Committee on Health **02/11/2020** Introduced	CalOptima: Watch
SB 910 Pan	**CalAIM Population Health Management:** Would require Medi-Cal managed care plans (MCPs) to implement the population health management program for those deemed eligible, effective January 1, 2022. Would require the Department of Health Care Services to utilize an external quality review organization (EQRO) to evaluate the effectiveness of the enhanced care management and in-lieu-of services provided to beneficiaries by each MCP. Additionally, would require each MCP to consult with stakeholders, including, but not limited to, county behavioral health departments, public health departments, providers, community-based organizations, consumer advocates, and Medi-Cal beneficiaries, on developing and implementing the population health management program.	**02/03/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 916 Pan	**CalAIM Enhanced Care Management and In-Lieu-Of Services:** Similar to AB 2042, would require enhanced care management as a covered benefit for Medi-Cal beneficiaries, including the coordination of all primary, acute, behavioral, oral, and long-term services and supports. Additionally, would require the Medi-Cal managed care plan to include a variety of in-lieu-of services as an optional benefit for beneficiaries posted on their website and in the beneficiary handbook.	**02/03/2020** Introduced	CalOptima: Watch

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4618 McBath	**Medicare Hearing Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of hearing aids for Medicare beneficiaries. Hearing aids would be provided every five years and would require a prescription from a doctor or qualified audiologist.	**10/17/2019** Passed the Committee on Energy and Commerce **10/08/2019** Introduced	CalOptima: Watch
H.R. 4650 Kelly	**Medicare Dental Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of dental health services for Medicare beneficiaries. Covered benefits would include preventive and screening services, basic and major treatments, and other care related to oral health.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
H.R. 4665 Schrier	**Medicare Vision Act of 2019:** No sooner than January 1, 2022, would require Medicare Part B to cover the cost of vision care for Medicare beneficiaries. Covered benefits would include routine eye exams and corrective lenses. Corrective lenses covered would be either one pair of conventional eyeglasses or contact lenses.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
AB 1904 Boerner Horvath	**Maternal Physical Therapy:** Would include pelvic floor physical therapy for women post-pregnancy as a Medi-Cal benefit.	**01/17/2020** Referred to Committee on Health **01/08/2020** Introduced	CalOptima: Watch
AB 1965 Aguiar-Curry	**Human Papillomavirus (HPV) Vaccine:** Would expand comprehensive clinical family planning services under the program to include the HPV vaccine for persons of reproductive age.	**01/30/2020** Referred to Committee on Health **01/21/2020** Introduced	CalOptima: Watch
AB 2258 Reyes	**Doula Care:** Would require full-spectrum doula care to be included as a covered benefit for pregnant and postpartum Medi-Cal beneficiaries. The program would be established as a 3-year pilot program in 14 counties, including the County of Orange, beginning July 1, 2021. Prior authorization or cost-sharing to receive doula care would not be required.	**02/20/2020** Referred to Committee on Health **02/13/2020** Introduced	CalOptima: Watch

DENTAL

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2535 Mathis	**Denti-Cal Education Pilot Program:** Would establish a 5-year pilot program to provide education and training to Denti-Cal providers providing care to individuals who attend a regional center and are living with a developmental disability. Additionally, Denti-Cal providers who participate in the pilot program and complete the required continuing education units would be eligible for a supplemental provider payment. The supplemental provider payment amount has yet to be defined by the Department of Health Care Services.	**02/27/2020** Referred to Committee on Health **02/19/2020** Introduced	CalOptima: Watch

ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Legislative Analyst's Office projects this expansion would cost approximately $900 million General Fund (GF) in 2019-2020 and $3.2 billion GF each year thereafter, including the costs if In-Home Supportive Services.	**07/02/2019** Hearing canceled at the request of the author **06/06/2019** Referred to Senate Committee on Health **05/28/2019** Passed Assembly floor **12/03/2018** Introduced	CalOptima: Watch CAHP: Support LHPC: Support
AB 526 Petrie-Norris	**Women, Infants, and Children (WIC) to Medi-Cal Express Lane:** Similar to SB 1073, would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for WIC to Medi-Cal. WIC, within the Children's Health Insurance Program, is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program through the express lane. Of note, the express lane program was never implemented due to a lack of funding.	**08/30/2019** Senate Committee on Appropriations; Held under submission **06/27/2019** Passed Senate Committee on Health **05/23/2019** Passed Assembly floor **02/13/2019** Introduced	CalOptima: Watch
AB 683 Carrillo	**Adjusting the Assets Test for Medi-Cal Eligibility:** Would eliminate specific assets tests, such as life insurance policies, musical instruments, and living trusts, when determining eligibility for Medi-Cal enrollment.	**05/16/2019** Committee on Appropriations; Hearing postponed at the request of the Committee **04/02/2019** Passed Committee on Health **02/15/2019** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 29 Durazo	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 65 years or older, regardless of their immigration status. The Assembly Appropriations Committee projects this expansion would cost approximately $134 million each year ($100 million General Fund, $21 federal funds) by expanding full-scope Medi-Cal to approximately 25,000 adults who are undocumented and 65 years of age and older. The financial costs for In-Home Supportive Services is estimated to cost $13 million General Fund.	**09/13/2019** Held in Assembly **05/29/2019** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
SB 1073 Gonzalez	**Women, Infants, and Children (WIC) to Medi-Cal Express Lane:** Similar to AB 526, would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for WIC to Medi-Cal. WIC, within the Children's Health Insurance Program, is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program through the express lane. Of note, the express lane program was never implemented due to a lack of funding.	**02/18/2020** Introduced	CalOptima: Watch

HOMELESSNESS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1978 Correa/Lieu	**Fighting Homelessness Through Services and Housing Act:** Similar to S. 923, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to the House Committee on Financial Services	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
S. 923 Feinstein	**Fighting Homelessness Through Services and Housing Act:** Similar to H.R. 1978, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to Committee on Health, Education, Labor, and Pensions	CalOptima: Watch
AB 1907 Santiago, Gipson, Quirk-Silva	**California Environmental Quality Act (CEQA) Exemption for Emergency Shelters and Supportive Housing:** Would exempt the development of emergency shelters, supportive housing or affordable housing by a public agency from CEQA regulations, expiring on December 31, 2028.	**01/30/2020** Referred to Committees on Natural Resources; Housing and Community Development **01/08/2020** Introduced	CalOptima: Watch
AB 2295 Quirk-Silva	**Fairview Developmental Center:** Would require the State Legislature to enact legislation relating to the development of the Fairview Developmental Center (Center) located in Costa Mesa, CA. Of note, the Governor's Fiscal Year 2019-2020 budget included funds to utilize the Center temporarily to provide housing and services for those experiencing a severe mental illness. Additionally, AB 1199, signed into law in 2019, allows a public hearing to determine the use of the Center. This bill is still early in the legislative process. The pending legislation to define use of the Center is unknown at this time.	**02/14/2020** Introduced	CalOptima: Watch
AB 2746 Petrie-Norris, Gabriel	**Accountability of State Funds Used for Homelessness:** Would require an agency that receives state funds for programs related to homelessness, including, but not limited to, the Whole-Person Care pilot program, California Work Opportunity and Responsibility to Kids (CalWORKs), or the Housing and Disability Income Advocacy Program, to submit a report regarding the use of state funds. The report would be sent to the state agency granting funds for these programs. Additionally, would require the report to the state agencies to be submitted within 90 days of receiving program funds, or by April 1, 2021, if the recipient already received program funds as of January 1, 2021.	**05/05/2020** Referred to Committee on Housing and Community Development **02/20/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2848 Santiago	**Homelessness Reduction Plan:** Would require each city or county to develop a plan to reduce homelessness by no less than 10% each year through a state mandate. The plan would be effective no later than January 1, 2022 and would be under the direction of the state's Homeless Coordinating and Financing Council. Additionally, would authorize the Office of the Inspector General to enforce a state or local agency to be in compliance with the Homeless Reduction Plan.	**04/24/2020** Referred to Committee on Housing and Community Development **02/20/2020** Introduced	CalOptima: Watch
AB 3269 Chiu	**State and Local Homelessness Reduction Plan:** Would require state and local agencies aim at reducing homelessness by 90% by December 31, 2028. Would establish the Office of the Housing and Homelessness Inspector General to monitor the reduction plan and to bring action against a state and local agency that fails to adopt and implement a homelessness reduction plan within a reasonable time frame. Additionally, on or before January 1, 2022, each state and local agency shall develop an actionable plan to reduce homelessness and submit that plan to the Homeless Coordinating and Financing Council.	**05/05/2020** Referred to Committee on Housing and Community Development **02/21/2020** Introduced	CalOptima: Watch
AB 3300 Bloom, Bonta, Gipson, Quirk-Silva, Santiago, Wicks	**California Access to Housing and Services Act:** Would authorize the Department of Finance to allocate $2 billion General Fund to establish the California Access to Housing and Services Fund.	**05/05/2020** Referred to Committee on Housing and Community Development **02/21/2020** Introduced	CalOptima: Watch

MEDI-CAL MANAGED CARE PLANS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2625 Boerner Horvath	**Ground Emergency Medical Transportation (GEMT):** Would require managed care plans that offers coverage for GEMT services to include those services as in-network services.	**03/02/2020** Referred to Committee on Health **02/20/2020** Introduced	CalOptima: Watch
AB 2836 Chen	**Medi-Cal Emergency Medical Transportation Reimbursement Act:** Would impose a quality assurance fee (QAF) for each emergency medical transport provided by an emergency medical transport provider, beginning Fiscal Year 2021-2022. Would require the Department of Health Care Services to calculate the annual QAF to a specified program period at least 150 days before the start of the fiscal year. The bill would also redefine "emergency medical transport provider" to mean any provider of emergency medical transports, except during the entirety of any Medi-Cal managed care rating period.	**05/05/2020** Referred to Committee on Health **02/20/2020** Introduced	CalOptima: Watch
SB 936 Pan	**Medi-Cal Managed Care Plans Contract Procurement:** Would require the Department of Health Care Services Director to conduct a contract procurement at least once every five years with a contracted commercial Medi-Cal managed care plan providing care for Medi-Cal beneficiaries on a state-wide or limited geographic basis.	**02/20/2020** Referred to Committee on Health **02/06/2020** Introduced	CalOptima: Watch

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1938 Low, Eggman	**340B Discount Drug Purchasing Program:** Would define a "designated entity" eligible for the 340B discount drug purchasing program as a nonprofit organization, including any subsidiary of that organization, that individually or collectively meets specific requirements. This would require: ■ The designated entity to be a licensed managed care organization that has previously contracted with the department as a primary care case management organization; ■ The designated entity to be contracted with the federal Centers for Medicare and& Medicaid Services (CMS) to provide services in the Medicare Program as a Medicare special needs plan; and ■ The designated entity to be an existing participant of the 340B program. Additionally, would prohibit a designated entity from using any revenue from a contract with the Department of Health Care Services, a contract with CMS, and from the 340B program for specific activities, such as: ■ Funding litigation under the California Environmental Quality Act; or ■ Influencing or funding any ballot measure actions related to housing.	**05/05/2020** Re-referred to Committee on Health **01/17/2020** Introduced	CalOptima: Watch
AB 2100 Wood	**Pharmacy Carve-Out Benefit:** Would require the Department of Health Care Services to establish the Independent Prescription Drug Medical Review System (IPDMRS) for the outpatient pharmacy benefit, and to develop a framework for the system that models the requirements of the Knox-Keene Health Care Service Plan Act. Would require the IPDMRS to review disputed health care service of any outpatient prescription drug eligible for coverage and payment by the Medi-Cal program that has been denied, modified, or delayed or to a finding that the service is not medically necessary. Additionally, would establish prior authorization requirements, such as a 24-hour response, a 72-hour supply during emergency situations, and a minimum 180 days for continuity of care for medications regardless if listed on the Medi-Cal contract drug list.	**02/20/2020** Referred to Committee on Health **02/05/2020** Introduced	CalOptima: Watch
AB 2348 Wood	**Pharmacy Benefit Management (PBM):** Would require a PBM, who contracts with a health care service plan, beginning on October 1, 2021, to report to the Department of Managed Health Care the PBM's revenue, expenses, health care service plan contracts, the scope of services provided to that plan, and the number of enrollees the PBM serves. The PBM would also be required to submit a report on all covered prescription drugs, including generic, brand name, and specialty drugs dispenses at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use.	**05/05/2020** Referred to the Committee on Health **02/18/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 852 Pan	**California Affordable Drug Manufacturing Act of 2020:** Would establish the Office of Drug Contracting and Manufacturing (Office) to reduce the cost of prescription drugs. No later than January 1, 2022, would require the Office to contract or partner with no less than one drug company or generic drug manufacturer, licensed by the United States Food and Drug Administration, to produce or distribute generic prescription drugs.	**01/13/2020** Introduced	CalOptima: Watch
SB 1084 Umberg	**Secure Dispensing of a Controlled Substance:** Would require a pharmacist who dispenses a controlled substance in a pill form to dispense the controlled substance in a lockable vial no sooner than June 30, 2021. Would require the manufacturer of the controlled substance to reimburse the pharmacy dispensing the medication the cost of using a lockable vial within 30 days of receiving a claim. Would also require the pharmacy to provide educational pamphlets to the patient regarding the use of a controlled substance.	**03/05/2020** Referred to Committees on Business, Professions and Economic Development; Judiciary **02/19/2020** Introduced	CalOptima: Watch

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2492 Choi	**Program of All-Inclusive Care for the Elderly (PACE) Enrollment:** Would require the Department of Health Care Services to establish a maximum number of eligible participants each PACE center can enroll.	**03/12/2020** Referred to Committees on Aging; Long-Term Care **02/19/2019** Introduced	CalOptima: Watch CalPACE: Oppose
AB 2604 Carrillo	Pandemic and Health-Related Emergency Protocols for Health Facilities Act: During a health-related state of emergency or local emergency, would require a health facility to limit the possible introduction of a pathogen, infection, or illness that is related to a pandemic or emergency by: ■ Postponing non-emergency medical procedures or office visits; ■ Prohibiting or limiting visitors of patients to the health facility; ■ Ensuring all patients and staff are always wearing surgical masks or personal protective equipment; ■ Providing education and enforcing regarding hand hygiene and cough etiquette for patients and staff; ■ Regularly disinfecting the health facility at least three times per day; ■ Adding air cleaning equipment to ventilation systems; ■ Establishing contaminated, partially contaminated, and clean zones with buffers between each of the three zones; ■ Implementing outdoor triage stations; and ■ Considering all patients to have "suspected cases' of the pathogen, infection, or illness until ruled out or confirmed.	**05/07/2020** Re-referred to Committee on Labor and Employment **02/21/2020** Introduced	CalOptima: Watch

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 890 Wood	**Nurse Practitioners:** Would permit a nurse practitioner to practice without direct, ongoing supervision of a physician when practicing in an office managed by one or more physicians. Would create the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs to certify nurse practitioners wanting to practice without direct, ongoing supervision of one or more physicians.	**01/27/2019** Passed Assembly floor **02/20/2019** Introduced	CalOptima: Watch LHPC: Support

REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 66 Atkins/ McGuire	**Federally Qualified Health Center (FQHC) Reimbursement**: Would allow an FQHC to be reimbursed by the state for a mental health or dental health visit that occurs on the same day as a medical face-to-face visit. Currently, California is one of the few states that do not allow an FQHC to be reimbursed for a mental or dental and physical health visits on the same day. A patient must seek mental health or dental treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would distinguish a medical visit through the member's primary care provider and a mental health or dental visit as two separate visits, regardless if at the same location on the same day. As a result, the patient would no longer have to wait a 24-hour time period in order to receive medical and dental or mental health services, while ensuring that clinics are appropriately reimbursed for both services. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC.	**09/13/2019** Carry-over bill; Moved to inactive filed at the request of the author **08/30/2019** Passed Assembly Committee on Appropriations **05/23/2019** Passed Senate floor **01/08/2019** Introduced	CalOptima: Watch CAHP: Support LHPC: Co-Sponsor, Support
AB 2871 Fong	**Drug Medi-Cal Reimbursement Rates:** Would require the Department of Health Care Services to establish reimbursement rates for services provided through the Drug Medi-Cal program to be equal to rates for similar services provided through the Medi-Cal Specialty Mental Health Services program.	**03/05/2020** Referred to Committee on Health **02/21/2020** Introduced	CalOptima: Watch

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4932 Thompson	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to S. 2741, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Committees on Energy and Commerce; Ways and Means	CalOptima: Watch AHIP: Support
S. 2741 Schatz	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to H.R. 4932, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Senate Committee on Finance	CalOptima: Watch AHIP: Support
AB 1676 Maienschein	**Telehealth Mental Health Services for Children, Pregnant Women, and Postpartum Persons:** Would create a telehealth program used to conduct mental health consultations and treatments for children, pregnant women, and postpartum persons, effective no sooner than January 1, 2021. Consultation and treatment services, provided by a psychiatrist, would be accessible during standard business hours, with the option for evening and weekend hours. Would also require adequate staffing to ensure calls are answered within 60 seconds. Payment structure has yet to be defined.	**05/16/2019** Committee on Appropriations; Held under submission **04/24/2019** Passed Committee on Health **02/22/2019** Introduced	CalOptima: Watch CAHP: Oppose

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2164 Rivas, Salas	**Telehealth Pilot Program and Expanding Access to Telehealth:** Would establish a five-year grant and pilot program, to establish the eConsult Services and Telehealth Assistance Program. The grant funding would be available to health centers and community clinics providing care in rural and underserved areas. The pilot program is projected to cost $7.5 million over five-years and would be use for: ■ Conducting infrastructure assessments, clinical objectives, and staffing plans; ■ Procuring technology and software and implementing eConsult services; and ■ Workforce training. Additionally, would no longer require the first visit at a federally qualified health clinic to be an in-person visit by authorizing telehealth appointments that occur by synchronous real time or asynchronous store and forward. This would allow the new patient the option to utilize telehealth services and become an established patient as their first visit.	**05/12/2020** Re-referred to Committee on Health **02/11/2020** Introduced	CalOptima: Watch
AB 2360 Maienschein	**Telehealth Mental Health Services for Children, Pregnant Women, and Postpartum Persons:** Similar to AB 1676, which was held under submission by the Assembly Committee on Appropriations in 2019, would create a telehealth program used to conduct mental health consultations and treatments for children, pregnant women, and postpartum persons, effective no sooner than January 1, 2021. Consultation and treatment services, provided by a psychiatrist, would be accessible during standard business hours, with the option for evening and weekend hours.	**05/11/2020** Re-referred to Committee on Health **02/19/2020** Introduced	CalOptima: Watch
SB 1278 Bradford	**Health Care Provider License for Telehealth:** Would require that accepted standards of practice applicable to a health care provider under the health care provider's license shall also apply to that health care provider while providing telehealth services.	**03/05/2020** Referred to Committee on Business, Professions and Economic Development **02/21/2020** Introduced	CalOptima: Watch

TRAILER BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
RN 2002918 Trailer Bill – Medi-Cal Expansion	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals 65 years of age or older regardless of their immigration status. The Governor's Fiscal Year 2020-2021 proposed budget anticipates the expansion of full-scope Medi-Cal will cost $80.5 million ($62.4 million General Fund) in 2021 and $350 million ($320 million General Fund) each year after, including the cost of In-Home Supportive Services.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
RN 2003830 Trailer Bill: Drug Price Negotiations	**Med-Cal Drug Pricing Negotiations:** Would authorize the Department of Health Care Services negotiate "best prices" with drug manufacturers, both within and outside of the United States, and to establish and administer a drug rebate program in order to collect rebate payments from drug manufacturers for drugs furnished to California residents who are ineligible for full-scope Medi-Cal. Would authorize a Medi-Cal beneficiary to receive more than six medications without prior approvals. Additionally, this Trailer Bill would modify the current co-pay amount for a drug prescription refill.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch
RN 2006526 Trailer Bill – Medication-Assisted Treatment	**Medication-Assisted Treatment (MAT):** Would expand narcotic treatment program services to include MAT under Drug Medi-Cal.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Managed Care Savings and Efficiencies	**Managed Care Savings and Efficiencies:** In alignment with the 2020-2021 State Budget May Revise, would reduce Medi-Cal capitation rate increments by up to 1.5 percent for capitation rates associated with the July 1, 2019 through December 31, 2020 rate period. Additionally, the Department of Health Care Services (DHCS) would be able to apply these reduced capitation rates for rating periods starting on or after January 1, 2021 and to account for the impacts of the COVD-19 public health emergency. To ensure capitation rates are actuarily sound, DHCS would be required to evaluate the impact of the changes in the level of health care funding for health care services on capitation rates it develops and pays under any applicable managed care health plan contract with a Medi-Cal managed care plan.	**05/14/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Federally Qualified Health Center and Rural Health Clinic Prospective Payment System Carve-Outs	**Elimination of Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Prospective Payment System (PPS) Carve-Outs for Pharmacy and Dental Services:** Would require all Medi-Cal covered services provided by an FQHC or RHC, including but not limited to pharmacy and dental services, to be reimbursed only through the clinic's PPS rate, effective January 1, 2021. If an FQHC or RHC is unable to revert to its prior base PPS rate, it would be required to adjust the FQHC or RHC PPS base rate through scope-of-service adjustments. Of note, this Trailer Bill language would exclude any payment changes for services related to specialty mental health and Drug Medi-Cal.	**05/14/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Proposition 56 Payments	**Sunset of Proposition 56 Value-Based Payments:** In alignment with the 2020-2021 State Budget May Revise, would eliminate the Proposition 56 Value-Based Payment Program for provider incentive payments, effective July 1, 2020.	**05/14/2020** Published on the Department of Finance website	CalOptima: Watch

*Information in this document is subject to change as bills are still going through the early stages of the legislative process.

CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: May 18, 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 13	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
June 4, 2020

CalOptima Community Outreach Summary — May 2020

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events and public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima's staff actively participates in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Event Update

As an essential service, COVID-19 has transitioned nearly 90% of CalOptima employees to telework, which has significantly changed our daily work routine. Like many of our colleagues, Community Relations (CR) has adjusted to remain engaged with the Orange County community. Staying connected and being able to update our community partners is more important than ever, as many people are in need of resources and have questions related to Medi-Cal. Luckily, with the help of Information Services (IS), CR remains connected to the community via conference calls or virtually, through GoToMeetings.

Our ongoing communication with community-based organizations recently led to the distribution of CalOptima branded items. We were proud to provide 300 CalOptima branded reusable bags with the Vietnamese American Cancer Foundation, who used the bags to provide emergency aid kits and food to patients with cancer and patients in remission.

The CR team continues to attend collaborative meetings with community partners. These days attending a meeting looks a little different, as all community meetings have transitioned to virtual formats. In April, CR participated in 16 meetings via conference call or virtual format. Meetings were hosted by organizations such as the Garden Grove Community Collaborative, Fullerton Collaborative, San Clemente Youth Wellness and Prevention Coalition and Kid Healthy, just to name a few. May is looking busier with 19 community meetings scheduled for CR to attend.

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Additionally, CR distributes weekly COVID-19 Community Announcements to share member and provider updates and government and local resources with community partners who serve CalOptima members. It is our hope that by remaining engaged, it serves as a reminder to our community that they are not alone, and we are Better. Together.

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 May 5, 2020, **through virtual meetings and teleconference** CalOptima expects to participate in 27 community events, coalitions and committee meeting and does not anticipate in participating in any others during May.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
5/05/2020	• Collaborative to Assist Motel Families Meeting (Virtual Meeting)
5/07/2020	• Garden Grove Community Collaborative Advisory Meeting (Virtual Meeting)
5/08/2020	• Orange County Diabetes Collaborative (Virtual Meeting)
5/11/2020	• Orange County Veteran's and Military Families Collaborative (Virtual Meeting) • Fullerton Collaborative Meeting (Format Pending)
5/12/2020	• Youth and Wellness Prevention Coalition (Virtual Meeting) • Orange County Cancer Coalition (Virtual Meeting)
5/13/2020	• Orange County Communications Workgroup (Teleconference Meeting)
5/14/2020	• Kid Healthy Community Advisory Council (Virtual Meeting) • Garden Grove Community Collaborative General Meeting (Format Pending) • Buena Park Collaborative Meeting (Format Pending) • State Council on Developmental Disabilities Regional Advisory Committee Meeting (Virtual Meeting) • Orange County Women's Health Project Advisory Board Meeting (Virtual Meeting) • API Community Outreach Meeting (Virtual Meeting)
5/18/2020	• Stanton Community Collaborative Meeting (Virtual Meeting) • Orange County Health Care Agency Mental Health Services Act Steering Committee

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5/19/2020	• Placentia Community Collaborative Meeting (Format Pending) • North Orange County Senior Collaborative All Members Meeting (Format Pending)
5/20/2020	• La Habra Community Collaborative Meeting (Format Pending) • Covered Orange County Steering Committee Meeting (Format Pending) • Minnie Street Family Resource Center Meeting (Format Pending)
5/21/2020	• Orange County Children's Partnership Committee Meeting (Format Pending) • Orange County Youth Service Providers Consortium (Sponsorship Fee: $600 included agency's logo and an ad promoting agency's programs and services on a PowerPoint presentation slide that will be displayed periodically throughout the virtual event.) (Virtual Format)
5/26/2020	• Orange County Senior Roundtable (Format Pending)
5/28/2020	• Orange County Care Coordination for Kids (Virtual Meeting) • Orange County Youth Service Providers Consortium (Sponsorship Fee: $600 included agency's logo and an ad promoting agency's programs and services on a PowerPoint presentation slide that will be displayed periodically throughout the virtual event.) (Virtual Format)
5/29/2020	• Orange County Women's Health Summit (Sponsorship Fee: $1,000 included agency's logo and information in digital program, recognition of agency's sponsorship throughout virtual event.) (Virtual Format)

As of May 5, 2020, CalOptima expects to organize or convene one community stakeholder event, meeting or presentation through virtual meeting or teleconference and does not anticipate participating in any others during May.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	**Events/Meetings/Presentations**
5/21/20	• Health Network Forum (Virtual Meeting)

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. Provided a Letter of Support to Boat People SOS-CA (BPSOS) Center for the Community Advancement for the National Community Care Corps grant for new and/or innovative approaches to address the needs of Vietnamese and other minority older adults, and adults with intellectual/developmental disabilities, and their families and caregivers.

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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 marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings, including coalitions, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

In response to the COVID-19, CalOptima is transitioning how we engage with our community partners and will not be attending in-person Community Collaborative meetings. In addition, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19. CalOptima has updated our participation in Community Collaborative meetings and community events. With respect to events that have been cancelled or postponed due to COVID-19 where sponsorship or fees have been paid, event organizers will have the option to refund previously pre-paid participation fees or apply paid sponsorship fees to any future events, provided

+ Exhibitor/Attendee
++ Meeting Attendee

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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.

June

Date and Time	Event Title	Event Type/Audience	Staff/ Financial Participation	Location
Tuesday, 6/2 9:30–11 a.m. (Pending)	++ Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Wednesday, 6/3 9–10:30 a.m. (Virtual format)	++ OC Aging Services Collaborative General Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimers Association OC 2515 McCabe Way Irvine
Wednesday, 6/3 10 a.m.–12 p.m. (Pending)	++ Anaheim Human Services Network	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Community Center 250 E. Center St. Anaheim
Wednesday, 6/3 10:30 a.m.–12 p.m. (Virtual format)	++ Orange County Healthy Aging Initiative/OCSPA Healthcare Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimers Association OC 1515 McCabe Way Irvine
Thursday, 6/4 9–11 a.m. (Virtual format)	++ Continuum of Care Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 6/4 11 a.m.–1 p.m. (Virtual format)	++ Garden Grove Community Collaborative Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Courtyard Center 12732 Main St. Garden Grove

+ Exhibitor/Attendee
++ Meeting Attendee

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Monday, 6/8 1–2:30 p.m. (Virtual format)	++ Orange County Veterans and Military Families Collaborative - Children and Family Working Group	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 6/8 2:30–3:30 p.m. (Virtual format)	++ Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 6/9 10–11:30 p.m. (Virtual format)	++ Orange County Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Susan G. Komen OC 2817 McGaw Ave. Irvine
Tuesday, 6/9 3:30–5:30 p.m. (Virtual format)	++ San Clemente Youth Wellness and Prevention Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	189 Avenida La Cuesta San Clemente
Wednesday, 6/10 12–1:30 p.m. (Pending)	++ Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Thursday, 6/11 10 –11:30 p.m. (Pending)	++ Buena Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Community Center 6640 Beach Blvd. Buena Park
Thursday, 6/11 12:30–1:30 p.m. (Conference call)	++ Kid Healthy Community Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	OneOC Building C 1901 E. Fourth St. Santa Ana
Thursday, 6/11 2:30–4:30 p.m. (Pending)	++ Orange County Women's Health Project Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Monday, 6/15 1–4 p.m. (Pending)	++ OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Delhi Community Center 505 E. Central Ave. Santa Ana
Tuesday, 6/16 11 a.m.–12 p.m. (Pending)	++ Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Placentia Library Community Room 411 Chapman Ave. Placentia
Wednesday, 6/17 9–10:30 a.m. (Conference call)	++ Covered Orange County Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana

+ Exhibitor/Attendee
++ Meeting Attendee

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Wednesday, 6/17 11 a.m.–1 p.m. (Pending)	++ Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	1300 McFadden Ave. Santa Ana
Wednesday, 6/17 3:30–4:30 p.m. (Conference call)	++ Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Thursday, 6/18 8:30–10 a.m. (Pending)	++ Orange County Children's Partnership Committee (OCCP)	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Monday, 6/22 12:30–1:30 p.m. (Virtual format)	++ Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 6/23 7:30–9 a.m. (Pending)	++ OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Thursday, 6/25 1:30–3:30 p.m. (Virtual format)	++ Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	CHOC Centrum Building 1120 W. La Veta Orange

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

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