**NOTICE OF A**
**REGULAR MEETING OF THE**
**CALOPTIMA BOARD OF DIRECTORS**

**THURSDAY, SEPTEMBER 5, 2019**
**2:00 P.M.**

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

BOARD OF DIRECTORS

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

Supervisor Doug Chaffee, Alternate

| CHIEF EXECUTIVE OFFICER | CHIEF COUNSEL | INTERIM CLERK OF THE BOARD |
|---|---|---|
| Michael Schrader | Gary Crockett | Sharon Dwiers |

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

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

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

**CALL TO ORDER**
Pledge of Allegiance
Establish Quorum

**PRESENTATIONS/INTRODUCTIONS**

## MANAGEMENT REPORTS

1. Chief Executive Officer Report
    a. Homeless Health Initiatives
    b. Strategic Planning Session
    c. Medi-Cal Pharmacy Benefit Carve-Out
    d. PACE Enrollment
    e. Federal Budget
    f. Public Charge Rule
    g. Network Adequacy of Delegated Entities

## PUBLIC COMMENTS

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

## CONSENT CALENDAR

2. Minutes
    a. Consider Approving Minutes of the August 1, 2019 Regular Meeting of the CalOptima Board of Directors and the August 9, 2019 Special Meeting of the CalOptima Board of Directors
    b. Receive and File Minutes of the April 25, 2019 Regular Meeting of the OneCare Connect Member Advisory Committee; the June 13, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee; and the June 13, 2019 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee

3. Consider Authorizing Changes to Allowable Rates for Services Provided by Nurse Practitioners and Physician Assistants at the Program of All-Inclusive Care for the Elderly (PACE) Clinic

4. Consider Appointments to the CalOptima Board of Directors' Member Advisory Committee's Chair and Vice Chair

## REPORTS

5. Consider Ratifying Revisions to CalOptima Financial Policies and Procedures Related to the Whole-Child Model Program

6. Consider Authorizing Supplemental Payments to Health Networks for Specific Home Health Agency Services

7. 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 (PACE)

8. Consider Actions Related to CalOptima's Health Homes Program

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

10. Consider Authorizing Expenditures in Support of CalOptima Participation in Community Events

11. Consider Allocation of Intergovernmental Transfer (IGT) 5 Funds Towards a Community Grant(s) for Access to Children's Dental Services

**ADVISORY COMMITTEE UPDATES**

12. Provider Advisory Committee Update

13. Member Advisory Committee Update

**INFORMATION ITEMS**

14. CalOptima HealthCare Services Delivery Model Evaluation Update

15. July 2019 Financials

16. Compliance Report

17. Federal and State Legislative Advocates Report

18. CalOptima Community Outreach and Program Summary

**BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS**

**ADJOURNMENT**

# MEMORANDUM

DATE: September 5, 2019

TO: CalOptima Board of Directors

FROM: Michael Schrader, CEO

SUBJECT: CEO Report

COPY: Sharon Dwiers, Interim Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

**CalOptima Boosts Homeless Health Initiatives Through Meetings, Outreach Efforts**

To ensure awareness of CalOptima's commitment to improved homeless health, leaders and staff are working to engage various audiences. Below are summaries of several recent meetings.

- *Provider Workgroup:* On July 30, CalOptima launched the Outreach and Navigation Workgroup to keep health network and hospital leaders apprised of our homeless health efforts and to collaborate on enhancing the existing delivery model. Now meeting on a biweekly basis, the workgroup is discussing how to improve engagement of members experiencing homelessness and identifying best practices for delivering primary and preventive care within our delegated delivery system.
- *City Manager Meeting:* On August 20, members of CalOptima's executive team and I met with the city managers of Orange, La Habra and Buena Park, three of the 13 cities in the North Orange County Service Planning Area (SPA). The managers stated that the North SPA cities are in the process of establishing two homeless navigation centers in Buena Park and Placentia, including at least 200 beds, per local mandate. We shared information about the significant medical services and supports that would be available once the shelters open, including recuperative care, respite care, mobile clinics and clinical field teams.
- *Ad Hoc/Hospital Meeting:* On August 21, your Board's ad hoc committee on homeless health and CalOptima executives met with a group of hospital clinical leaders to discuss care transitions and discharges. Selected by the Hospital Association of Southern California, the group included representatives from St. Joseph Hospital, Orange County Global Medical Center, UCI Medical Center and Fountain Valley Regional Medical Center.
- *Shelter Visits:* CalOptima is reaching out to homeless shelter operators to build relationships and raise awareness about services. Thus far, staff and/or I have toured La Mesa Emergency Shelter in Anaheim, operated by Illumination Foundation; the Anaheim temporary shelter, operated by The Salvation Army; and the Tustin Temporary Emergency Shelter, known as the Village of Hope.
- *Clinical Field Team Presentations:* CalOptima Directors Sloane Petrillo (Case Management) and Debbie Kegel (Strategic Development) made two presentations about our clinical field team services, first to the staff at Orange County Rescue Mission and most recently to the Continuum of Care Board Emergency Shelter Committee, which included representatives from 12 shelters.
- *Shelter Survey:* The Continuum of Care Board Emergency Shelter Committee distributed a survey on behalf of CalOptima to help us learn about current and needed health care services

at shelters. The results will assist us in establishing predictable and recurring schedules for mobile clinics.

**Strategic Planning Session Considers Health Care Landscape, Identifies Priorities**
On August 9, CalOptima conducted a full-day Strategic Planning session for the Board and executive team, led by Chapman Consulting with separate featured presentations by Pacific Health Consulting Group and special guest Mark Ghaly, M.D., MPH, secretary, California Health and Human Services Agency. To set priorities for 2020–22, the session included an overview of the health care landscape and an assessment of the external forces on CalOptima. The discussion identified that the public is concerned about the cost of health care yet growingly supports the Medi-Cal program. Health care experts and advocates generally view public plans, like CalOptima, as part of the solution but are interested in increased oversight of managed care plans. From a regulatory standpoint, the Department of Health Care Services (DHCS) is focused on specific initiatives, such as population health, value-based payments, social determinants of health and integrated care. In this environment, Secretary Ghaly shared his strategic priorities of building a healthy California through expanded coverage, seeking value by balancing cost and quality, and focusing on Whole-Person Care and individuals who are the sickest and most medically complex. The outcome of the session was agreement on initial priority areas for CalOptima that pertain to members, value, stakeholders, sustainability and innovation. This month, we will define specific objectives and goals under each priority area. On October 10, CalOptima will hold a joint meeting for your Board's advisory committees to solicit feedback. A draft plan will be ready for Board review in November, with a final version to be considered for approval in December.

**Medi-Cal Pharmacy Benefit Carve-Out Moves Forward With a Request for Proposal (RFP); Legislators Express Concerns**
State Senate legislative leaders sent letters to DHCS Director Jennifer Kent requesting a 60-day delay in the final RFP for a statewide pharmacy benefit manager that would implement the governor's Medi-Cal pharmacy benefit carve-out plan. The leaders are calling for more time to allow for stakeholder feedback and RFP responses. The letters reflect the concerns that have been shared during significant advocacy efforts by our industry associations and a broad coalition of hospitals and clinics. DHCS released the final RFP on August 22; however, there is some indication that the department adjusted the RFP language to account for stakeholder concerns. The RFP does contain language that allows for the possibility of a delay in awarding the contract. Our associations are carefully reviewing the document and analyzing its potential impact.

**Program of All-Inclusive Care for the Elderly (PACE) Enrollment Growing Based on Efficient Processes Gained From PACE 2.0 Initiative**
In August, CalOptima PACE enrolled 19 new participants. This is the highest gross enrollment month to date, according to PACE Program Director Elizabeth Lee. The net gain in membership was 11, bringing the August census to 346 participants. Lee attributes this success to the center's participation in PACE 2.0, a collaborative program through the National PACE Association focused on scaling PACE programs through building capacity and streamlining processes. Lee said CalOptima PACE has experienced a significant reduction in the time from when an individual expresses interest in PACE to the first day of care. Further, the Alternative Care Setting (ACS) model is also contributing to enrollment gains. About 15% of PACE participants

currently receive their care at one of five contracted ACS centers. The team is working hard to balance growth and quality, and Lee expects that the strong enrollment performance realized in August is likely to continue.

**Two-Year Federal Budget Passes; Medicare Programs Protected From Sequestration Cut**
On August 2, President Trump signed HR 3877 into law, which provides a two-year framework for the federal budget through FY 2021. Congressional appropriations committees must now decide how much to spend on each federal program before the end of the fiscal year on September 30, 2019. The budget agreement prevents the implementation of automatic spending cuts, also known as sequestration, that are triggered when Congress misses budget deadlines. Medicaid funding is specifically exempted from sequestration cuts, but Medicare funding is not. A 2% cut to Medicare was set to be triggered on October 1 if Congress had not been able to pass a budget for FY 2020. The passage of HR 3877 means funding for OneCare and OneCare Connect programs will remain whole.

**Federal and State Regulatory Changes Affect Members, Health Networks**
Two regulatory changes have the potential to impact individuals receiving Medi-Cal services and the health networks that provide those services.

- *Public Charge:* The U.S. Department of Homeland Security released the final public charge rule, which goes into effect October 15. Under the rule, the federal government may deny legal permanent resident status or deny entry into the U.S. based on a determination of whether the individual is likely to become a public charge. Medicaid is included as a public benefit; therefore, receipt of the benefit will be considered a negative factor during public charge determinations. There are exceptions for certain cases, such as pregnancy and coverage for children. This past month, California Attorney General Xavier Becerra filed a lawsuit against the federal government, arguing the rule will have harmful human and financial impacts. One primary concern is the rule's chilling effect, which may lead individuals not to seek public services lest they risk their immigration status. Our trade associations are tracking this issue closely.
- *Network Adequacy of Delegated Entities*: DHCS has informed managed care plans that it intends to issue guidance describing how plans like CalOptima are expected to assess and certify the network adequacy of delegated entities, effective July 1, 2020. DHCS' forthcoming guidance is expected to indicate that delegated networks are subject to the same annual network certification requirements that the primary managed care plan is, including provider-to-member ratios, the presence of mandatory provider types, time and distance standards, and timely access standards. Health networks have historically been evaluated only at the aggregated, managed care plan level. This change is expected to create a significant administrative burden on CalOptima and our health networks. DHCS convened a workgroup of select managed care plan representatives and trade associations to discuss the content and impact of the guidance. CalOptima was one of the plans selected to participate in the workgroup over the coming weeks and months.

# MINUTES

## Regular Meeting
## of the
## CalOptima Board of Directors

**August 1, 2019**

A Regular Meeting of the CalOptima Board of Directors was held on August 1, 2019, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:01 p.m. Director Berger led the Pledge of Allegiance.

**ROLL CALL**

Members Present: Paul Yost, M.D., Chair; Dr. Nikan Khatibi, Vice Chair; Ria Berger; Ron DiLuigi; Alexander Nguyen, M.D.; Richard Sanchez (non-voting) (2:06 p.m.); Scott Schoeffel; Supervisor Andrew Do; Supervisor Michelle Steel

Members Absent: Lee Penrose

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

*Chair Yost reordered the agenda to hear Agenda Item 27, CalOptima HealthCare Services Delivery Model Evaluation Update after the Consent Calendar.*

**MANAGEMENT REPORTS**

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader highlighted several items from his CEO Report, including the Whole-Child Model (WCM) transition that occurred on July 1, 2019. He noted that CalOptima began providing California Children's Services (CCS) benefits to approximately 11,700 CCS-eligible CalOptima Medi-Cal members under the WCM program. Mr. Schrader also reminded the Board and the public that CalOptima is convening a Special Meeting on August 9, 2019 to start the Strategic Planning process for the next three years. He also shared the news of the passing of longtime Provider Advisory Committee Member, Dr. Theodore Caliendo.

**PUBLIC COMMENTS**

1. Lauren Beeler, South Coast Therapy – Oral Re: Agenda Item 1.a., Whole-Child Model Transition
2. Gerald Beeler, South Coast Therapy – Oral Re: Agenda Item 1.a., Whole-Child Model Transition
3. Leticia Ramos Rosales – Oral Re: Needs assistance with understanding and accessing benefits for a family member
4. Pamela Pimentel, MOMS Orange County – Oral Re: National Breastfeeding Awareness Month
5. Maura Mikulec, South County Homeless Task Force and Housing is a Human Right OC – Oral Re: Agenda Item 16, Consider Actions related to Homeless Health Care Delivery
6. Jesus Martinez, Healthy Smiles for Kids of Orange County – Oral Re: Agenda Item 15, Consider Allocation of Intergovernmental Transfer 5 Funds

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7. Charles V. Golden, DO FAAP, CHOC Children's – Oral Re: Agenda Item 14, Consider Allocation of Intergovernmental Transfer 6 and 7 Funds and Agenda Item 15, Consider Allocation of Intergovernmental Transfer 5 Funds
8. Mark Richard Daniels, Housing is a Human Right OC – Oral Re: Agenda Item 16, Consider Actions related to Homeless Health Care Delivery
9. Joy Torres, MHB Orange County -- Oral Re: Agenda Item 16, Consider Actions related to Homeless Health Care Delivery
10. Thomas Fielder, Housing is a Human Right OC -- Oral Re: Agenda Item 16, Consider Actions related to Homeless Health Care Delivery
11. David Duran, Peoples Homeless Task Force OC – Oral Re: Agenda Item 16, Consider Actions related to Homeless Health Care Delivery
12. Patrick Hogan, Homeless Advocate -- Oral Re: Agenda Item 16, Consider Actions related to Homeless Health Care Delivery
13. Mike Robbins, Peoples Homeless Task Force OC – Oral Re: Agenda Item 16, Consider Actions related to Homeless Health Care Delivery

## CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the June 27, 2019 Special Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the March 14, 2019 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee and the May 9, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

***Action:*** ***On motion of Director Berger, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 8-0-0)***

## INFORMATION ITEM

Bobbie Wunsch and Tim Reilly of Pacific Health Consulting Group (PHCG) presented an update on progress on their review of CalOptima's healthcare delivery system. Ms. Wunsch reminded the Board that PHCG is working with Andrew Naugle of Milliman, Inc. on this project. Ms. Wunsch explained that today's presentation will focus on the health network payment models, September's presentation will focus on models to motivate network outcomes, and the October presentation will report the findings and recommendations for CalOptima's healthcare delivery system.

Ms. Wunsch and Mr. Reilly provided an overview of the three basic types of networks, including the Direct Contracted Networks, the Partially Delegated Network, and Fully Delegated Network and summarized the differences between each type of network.

Ms. Wunsch and Mr. Reilly also provided a model overview of various Medi-Cal Managed Care organizations in California and the types of networks they use to provide care for assigned members. It was noted that the southern California region uses more capitation and delegation than northern California and LA Care and CalOptima were started out with heavily delegated delivery systems. They also provided comparative information on LA Care and the Inland Empire Health Plan (IEHP).

## REPORTS

3. Consider Authorizing Revision and Expansion of the Program for All-Inclusive Care for the Elderly Primary Care Provider Incentive and Related Changes to the PCP Contracts

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

*Action:* ***On motion of Director Nguyen, seconded and carried, the Board of Directors specific to the CalOptima PACE Program, authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to: 1) Revise the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Primary Care Physician (PCP) Incentive Program, subject to applicable regulatory approvals; 2) Ratify the amendment to CalOptima's current PACE PCP contracts to modify the PACE PCP Incentive Program; and Include the PACE PCP Incentive Program in any future PACE PCP contracts, including those of community-based physicians serving CalOptima PACE members. (Motion carried 6-0-1; Director Schoeffel absent; Supervisor Do abstained)***

4. Consider Authorizing the Chief Executive Officer to Negotiate Rates for Certain Fee-for-Service and Clinic Provider Contracts for CalOptima Program of All-Inclusive Care for the Elderly (PACE)

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

*Action:* ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to negotiate rates for certain fee-for-service (FFS) and PACE clinic provider contracts, within budget and rate guidelines and regulatory requirements. (Motion carried 6-0-1; Director Schoeffel absent; Supervisor Do abstained)***

5. Consider Authorizing and Directing Execution of Amendments to CalOptima's Primary Agreement with the California Department of Health Care Services Related to Rate Changes

*Action:* ***On motion of Director Berger, seconded and carried the Board of Directors authorized and directed the Chairman of the Board of Directors to execute Amendments to the Primary Agreement between the California Department of Health Care Services and CalOptima related to rate changes. (Motion carried; 8-0-0)***

6. Consider Authorizing and Directing the Execution of an Amendment to the Primary Agreement with the California Department of Health Care Services Related to the Addition of Covered Aid Codes

*Action:* ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute an***

***Amendment to the Primary Agreement between the California Department of Health Care Services and CalOptima related to the addition of covered aid codes. (Motion carried; 8-0-0)***

7. Consider Authorizing Approval of Revised Policy GG.1517, Transgender Services

***Action:*** ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized approval of revised Policy GG. 1517, Transgender Services. (Motion carried 8-0-0)***

8. Consider Authorizing Amendment to the Vision Service Plan HMO Services Contract
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

***Action:*** ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the Vision Service Plan (VSP) HMO Services Contract to increase the administrative capitation rates for Medi-Cal members effective August 1, 2019. (Motion carried 7-0-0; Director Schoeffel absent)***

9. Consider Ratifying Early Payment of the Prepayment for Services to be Provided to CalOptima Medi-Cal Members at the Be Well OC Wellness Hub Using Intergovernmental Transfer (IGT) 5 Funds
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

***Action:*** ***On motion of Director DiLuigi, seconded and carried, the Board of Directors Ratified the early payment of the prepayment for services to the Orange County Health Care Agency, in an amount of $11.4 million in Intergovernmental Transfer (IGT) 5 funds and authorized the Chief Executive Officer take such other steps, if any, as necessary to effectuate such prepayment. (Motion carried 7-0-0; Director Schoeffel absent)***

10. Consider Ratifying Amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Clinic Contracts Associated with St. Joseph Health
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Director DiLuigi did not participate in this item due to his affiliation with St. Jude Clinic.

***Action:*** ***On motion of Director Berger, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to ratify amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) clinics contracts associated with St. Joseph Health to: 1) Include all necessary language 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; 2) Reflect changes***

***associated with Proposition 56 program payments as authorized by the Board; and 3) Revise FFS rates for the provision of services to the extent as authorized by the Board. (Motion carried 6-0-0; Director Schoeffel absent; Director DiLuigi recused)***

11. Consider Ratifying Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist Contracts associated with St. Joseph Health

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisor Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act. Chair Yost did not participate in the discussion and vote due to his affiliation with Providence St. Joseph Health as a physician anesthesiologist.

***Action:*** ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to ratify amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service (FFS) Specialist Contracts associated with St. Joseph Health to: 1) Include all necessary language requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements; and 2) Reflect changes associated with Proposition 56 program payments to the extent as authorized by the Board; and 3) Revise FFS rates for the provision of services to the extent authorized by the Board. (Motion carried 5-0-1; Director Schoeffel absent; Supervisor Do abstained; Chair Yost recused)***

12. Consider Ratifying Amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist Contracts Associated with Children's Hospital of Orange County

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisor Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act. Chair Yost did not participate in the discussion and vote due to his affiliation with CHOC as a physician anesthesiologist.

***Action:*** ***On motion of Director Berger, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to ratify amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service (FFS) Specialist Contracts associated with Children's Hospital of Orange County (CHOC) to: 1) Include all necessary language 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; 2) Reflect changes associated with Proposition 56 program payments as authorized by the Board; and 3) Revise FFS rates for the provision of services to the extent authorized by the Board. (Motion carried 5-0-1; Director Schoeffel absent; Supervisor Do abstained; Chair Yost recused)***

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13. Consider Adoption of Resolution Approving and Adopting Updated Human Resources Policy

*Action:* ***On motion of Director DiLuigi, seconded and carried, the Board of Directors Adopted Resolution Approving CalOptima's Updated Human Resources Policy: GA.8058 Salary Schedule and GA.8058 Salary Schedule Attachment A (Motion carried 8-0-0)***

14. Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

Vice Chair Khatibi did not participate in this item due to potential conflicts of interest and left the room during discussion and vote due to his affiliation with Ahura Healthcare. Director Nguyen did not participate in this item due to potential conflicts of interest and left the room during discussion and vote due to his affiliation with UCI.

*Action:* ***On motion of Supervisor Do, seconded and carried, the Board of Directors approved the recommended allocations of IGT 6 and 7 funds in the amount of $19.1 million for community grants and internal projects; and authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into grant contracts with the recommended community grantees. (Motion carried 6-0-0; Vice Chair Khatibi and Director Nguyen absent)***

15. Consider Allocation of Intergovernmental Transfer 5 Funds

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

After considerable discussion, the Board directed staff to bring back details of the 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. The Board also approved the balance of recommended funding allocations for RFP 2., Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics) and RFP 3., Adult Dental Services totaling $2.4 Million to the recommended community grantees.

*Action:* ***On motion of Supervisor Steel, seconded and carried, the Board of Directors directed staff to return with additional information on RFP Category 1, Access to Children's Dental Services, and approved the balance of the recommended allocations of IGT 5 funds for RFP Categories 2 and 3, totaling $2.4 Million for community grants; and authorized the Chief Executive Officer, with the assistance of Legal Counsel, to execute grant contracts with the amended recommended community grantees. (Motion carried 5-2-0; Director Berger absent; Chair Yost; Directors DiLuigi and Schoeffel; Supervisors Do and Steel voting in favor of the motion; Vice Chair Khatibi and Director Nguyen voting no)***

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16. Consider Actions Related to Homeless Health Care Delivery

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

Supervisor Do requested that CalOptima post a schedule and/or produce a flyer of the dates and times when mobile clinics are scheduled to visit various shelters in Orange County.

***Action:*** ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the Chief Executive Officer to implement the following operational changes to support homeless health initiatives: a) Reallocate $135,000 in Fiscal Year (FY) 2019-20 Medi-Cal budgeted funds under homeless health-related initiatives from medical expenses to administrative expenses; b) Implement a pilot program to reimburse Federally Qualified Health Centers (FQHC) and FQHC Look-alikes directly for services provided via mobile health care units or in a fixed shelter location for dates of service from August 1, 2019 through March 31, 2020, based on the CalOptima Medi-Cal fee schedule and for eligible CalOptima Members notwithstanding health network assignment and continuing capitation payments; c) With the assistance of Legal Counsel, enter into contract amendments with FQHCs and FQHC Look-alikes providing mobile health care unit services; and Ratify contract amendment with Families Together of Orange County effective May 17, 2019 to participate in the CalOptima Clinical Field Team pilot program providing health care services for homeless members at their locations and provide start-up funding. (Motion carried 5-0-0; Director Schoeffel absent; Director DiLuigi and Supervisor Steel recused)***

17. Consider Development of a CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative

***Action:*** ***On motion of Director DiLuigi, seconded and carried, the Board of Directors 1) Authorized modification of the existing "CalOptima Day" Quality Improvement and incentive strategy to include a CalOptima Homeless Clinic Access Program (HCAP) that includes primary and preventive care services at Orange County homeless shelters and other locations in collaboration with Community Health Centers; 2) Authorized the expenditure of up to $1 million in provider incentives consistent with this proposed expansion of CalOptima Day quality improvement and incentive strategy; and 3) Authorized the hiring of two additional staff at an annual cost not to exceed $231,087 in support of this expansion of the CalOptima Day quality incentive program. (Motion carried 8-0-0)***

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18. Consider Medi-Cal Supportive Services Participation in the Housing for Healthy California Program

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

***Action:*** ***On motion of Director Berger, seconded and carried, the Board of Directors 1) With respect to the Grant application submitted by AFH Casa Paloma LP and by other developer applicants under Article I of the Department of Housing and Community Development Housing for Healthy California (HHC) Program, authorized the Chief Executive Officer (CEO) to provide such applicants whose target populations include CalOptima Medi-Cal Members with a letter of commitment for Medi-Cal supportive services in conjunction with their proposed participation for the program; 2) With respect to the Grant application submitted by the Orange County Health Care Agency (HCA) under Article II of the Department of Housing and Community Development Housing for Healthy California (HHC) Program; A) Authorized the CEO to provide HCA with a letter of commitment for Medi-Cal supportive services participation for the program; and B) Authorized the CEO, with the assistance of Legal Counsel, to enter into a Memorandum of Understanding (MOU) with HCA to coordinate Supportive Services and information exchange activities. (Motion carried 8-0-0; Director Sanchez absent)***

19. Consider Actions Related to CalOptima's Health Homes Program

Continued to a future meeting due to lack of a quorum.

20. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Continued to a future meeting due to lack of a quorum.

21. Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events

***Action:*** ***On motion of Director DiLuigi, seconded and carried, the Board of Directors 1) Authorized expenditures for CalOptima's participation in the following community events: a) Up to $10,000 and staff participation at the Vietnamese Cultural Center's 2019 Mid-Autumn Festival on Saturday, September 14, 2019 at Mile Square Park Freedom Hall in Fountain Valley; b) Up to $2,600 and staff participation in the Orange County Iranian American Chamber of Commerce (OCIACC) Health Expo on Saturday, September 14, 2019 at Quail Hill Community Center in Irvine; 2) Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3) Authorized the Chief Executive Officer to execute agreements as necessary for the events and expenditures. (Motion carried 8-0-0)***

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22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

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

***Action:*** ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021. (Motion carried 7-0-0; Director Schoeffel absent)***

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

***Action:*** ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors approved reappointment of the following individuals to serve two-year terms on the Member Advisory Committee, effective July 1, 2019 to June 30, 2021: a) Sandy Finestone as the Adult Beneficiaries Representative; b) Ilia Rolon as the Family Support Representative; c) Patty Mouton as the Medi-Cal Beneficiaries Representative; d) Suzanne Butler as the Persons with Disabilities Representative; e) Diana Cruz-Toro as the Recipients of CalWORKs Representative; and f) Mallory Vega as the Seniors Representative. (Motion carried 6-0-0; Supervisors Do and Steel absent)***

24. Consider Approval of New CalOptima Policy GA.4010: Service Animals

***Action:*** ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors authorized and approved new CalOptima Policy GA.4010: Service Animals. (Motion carried 6-0-0; Supervisors Do and Steel absent)***

## ADVISORY COMMITTEE UPDATES

25. Member Advisory Committee Update

Sally Molnar, MAC Chair, thanked the Board for approving the reappointments to the MAC. Ms. Molnar mentioned that the MAC is planning to discuss IGT funding at a future MAC meeting.

26. Provider Advisory Committee Update

John Nishimoto, PAC Chair, presented an update on the PAC's June 13, 2019 meeting and noted that a joint meeting with other CalOptima advisory committees is being scheduled in October and, that the committee will be meeting with Chapman Consulting regarding the work on the Strategic Plan.

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**INFORMATION ITEMS**

28. Behavioral Health In-House Transition
Donald Sharps, M.D., Medical Director of Behavioral Health, provided an update on CalOptima's planned transition to bring administration of behavioral health services in-house effective January 1, 2020 for CalOptima's Medicare programs. Dr. Sharps noted that Magellan currently continues to administer the OneCare and OneCare Connect behavioral health benefit for CalOptima, though administration of behavioral health services for CalOptima's Medi-Cal members and for Applied Behavioral Analysis (ABA) Services have already been transitioned and are administered internally.

The following Information Items were accepted as presented:
29. May and June Financial Summaries
30. Compliance Report
31. Federal and State Legislative Advocates Reports
32. CalOptima Community Outreach and Program Summary

**BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS**
Chair Yost reminded the Board Members that the strategic planning session is one week from tomorrow and encouraged all Board Members to attend.

Director Nguyen highlighted CalOptima's updated website and thanked staff for their work.

**ADJOURNMENT**
Hearing no further business, Chair Yost adjourned the meeting at 5:28 p.m. in honor of Dr. Theodore Caliendo, for his long-standing service.

*/s/ Sharon Dwiers*
Sharon Dwiers
Interim Clerk of the Board

*Approved: September 5, 2019*

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# MINUTES

## SPECIAL MEETING
## OF THE
## CALOPTIMA BOARD OF DIRECTORS

**August 9, 2019**

A Special Meeting of the CalOptima Board of Directors was held on August 9, 2019, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 10:08 a.m. Gary Crockett, Chief Counsel, led the Pledge of Allegiance.

**ROLL CALL**

Members Present: Paul Yost, M.D., Chair; Dr. Nikan Khatibi, Vice Chair; Ria Berger; Ron DiLuigi; Lee Penrose; Richard Sanchez (non-voting); Scott Schoeffel

Members Absent: Alexander Nguyen, M.D.; Supervisor Andrew Do; Supervisor Michelle Steel

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

**PUBLIC COMMENT**

There were no requests for public comment.

**INFORMATION ITEM**

1. 2020-22 CalOptima Strategic Planning Session

CEO Michael Schrader introduced Athena Chapman and Caroline Davis from Chapman Consulting, LLC, noting that most of the Board members and executive team had been interviewed by the consultants, and input provided in those interviews was used to help formulate today's strategic planning process.

Ms. Chapman provided an overview of the day and set the stage for how the strategic planning session would add to the information they learned from the Board and executive team interviews, as well as external stakeholders to guide CalOptima forward for the next three years.

Bobbie Wunsch and Tim Reilly from Pacific Health Consulting Group also presented an overview of the delivery system composition, financing, and innovations in health care in California and Orange County.

Mr. Schrader reviewed the current Strategic Plan, including key initiatives and progress made to date. Mr. Schrader also reminded the attendees that we are fortunate to have special guest Mark Ghaly, M.D., MPH, Secretary, California Health and Human Services Agency, in attendance to share his perspective on the current landscape of health care and to highlight important initiatives being driven at the state level, including an increased emphasis on results and on Medi-Cal Managed Care plans meeting deliverables set by the state.

The session included an overview of the health care landscape and impact of external forces on CalOptima, including the public concern about the cost of health care and growing support of the Medi-Cal program. Health care experts and advocates generally view public plans, like CalOptima, as part of the solution, but are interested in increased oversight of managed care plans. From a regulatory standpoint, Secretary Ghaly noted that the Department of Health Care Services (DHCS) is focused on a variety of specific initiatives, such as population health, value-based payments, social determinants of health and integrated care. Overlaying this environment, Secretary Ghaly shared his strategic priorities of building a healthy California through expanded coverage, seeking value by balancing cost and quality, and focusing on whole-person care and individuals who are the sickest and most medically complex. He also stressed the important role the managed care plans play in executing the strategies developed at the state level, noting that he would be very interested in further communications about innovative ideas the managed care plans have (e.g., such as those related to potential "emerging benefits"), but also that the plans should be following the state's lead on such topics.

After lengthy discussion the consultants agreed to continue to build a draft Strategic Plan around five priority areas for CalOptima: 1) Member-centric; 2) Value; 3) Stakeholders and External Parties; 4) Health Plan Sustainability; and 5) Proactive, Innovative Approach. In October, a joint meeting of the CalOptima Board's advisory committees will be held to solicit input and feedback on the objectives and goals of the Strategic Plan. Based on the current schedule, a draft of the Strategic Plan will be presented at the November Board meeting, and a final version will be presented for approval in December.

**BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS**
Chair Yost thanked staff for coordinating the all-day strategic planning session.

**ADJOURNMENT**
Hearing no further business, Chair Yost adjourned the meeting at 3:23 p.m.

*/s/ Sharon Dwiers*
Sharon Dwiers
Interim Clerk of the Board

*Approved: September 5, 2019*

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# MINUTES

## REGULAR MEETING OF THE
## CALOPTIMA BOARD OF DIRECTORS'
## ONECARE CONNECT
## CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN)
## MEMBER ADVISORY COMMITTEE

April 25, 2019

A Regular Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) was held on April 25, 2019 at CalOptima, 505 City Parkway West, Orange, California.

**CALL TO ORDER**
Chair Corzo called the meeting to order at 3:02 p.m. and led the Pledge of Allegiance.

**PUBLIC COMMENT**
Mike Robbins, Housing is a Human Right Orange County (HHROC), Mark Daniels, HHROC, Jeanine Robbins, HHROC, Rebecca Kovacs-Stein, HHROC, Joshua Collins, Homeless Advocates for Christ, and Wes Jones, Anaheim People's Homeless Taskforce – Oral re: Agenda Item VII.A. Homeless Health Update.

*Chair Corzo rearranged the agenda to hear Management Reports until quorum was attained.*

**CEO & MANAGEMENT REPORTS**

**Chief Medical Officer (CMO) Update**
David Ramirez, M.D., Chief Medical Officer, provided a verbal report on the importance of the member experience and quality member care. He noted that CalOptima is exploring the options of Telehealth and E-Consults for members. Dr. Ramirez also talked about the new Member Portal that will be available on the CalOptima website.

**INFORMATION ITEMS**

**OneCare Connect Member Benefits Overview Presentation**
Andrew Tse, Manager, OneCare Connect Customer Service, presented an overview of the OneCare Connect (OCC) benefits and the OCC Annual Notice of Change (ANOC).

**CalOptima Behavioral Health Presentation**
Donald Sharps, M.D., Medical Director, Behavioral Health, provided an OCC and OneCare (OC) Behavioral Health update. He noted the vendor Magellan Behavioral Health Care is continuing to manage OC and OCC mental health. Dr. Sharps also provided an update on the Medi-Cal behavioral health which transitioned from Magellan to CalOptima January 2018.

**Homeless Health Update**
Michael Schrader, Chief Executive Officer, provided a verbal update on the Homeless Health Initiative. He noted that CalOptima's Board of Directors' made a $100 million commitment to homeless health and have allocated another $40 million towards recuperative care. CalOptima in

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partnership with the County is providing recuperative care where homeless individuals can reside for up to 90 days. Mr. Schrader also noted that CalOptima had launched their clinical field teams in on April 10, 2019 and that these clinical field teams consisted of a physician and a medical assistant and will be available on an on-call basis. The Orange County Health Care Agency (OCHCA) is also providing an Outreach and Engagement Team known as the Blue Shirts to assist the clinical field teams. Mr. Schrader also provided a brief update on the four Orange County Federally Qualified Health Centers (FQHCs) currently working with CalOptima on this initiative.

*Chair Corzo requested a roll call at 4:15 p.m. to confirm that a quorum had been achieved.*

**ESTABLISH QUORUM**

Members Present: Gio Corzo, Chair; Chair; Patty Mouton, Vice Chair; Josefina Diaz, Sandy Finestone, Sara Lee, Jyothi Atluri (non-voting), Erin Ulibarri (non-voting), Keiko Gamez (4:03pm)

Members Absent: George Crits, M.D. (non-voting)

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Belinda Abeyta, Interim Executive Director Operations; Candice Gomez, Executive Director, Program Implementation; Emily Fonda, M.D., Medical Director, Medical Management; Donald Sharps, M.D., Medical Director, Behavioral Health; Albert Cardenas, Director, Customer Service (Medicare); Cheryl Simmons, Staff to the Advisory Committees, Customer Service; Samantha Fontenot, Program Specialist, Customer Service

**MINUTES**

**Approve the Minutes of the February 28, 2019 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee**

***Action:*** ***On motion of Vice Chair Mouton, seconded and carried, the Committee approved the minutes of the February 28, 2019 meeting. (Motion carried 6-0-0)***

**REPORTS**

**Consider Approval of the FY 2019-2020 OCC MAC Meeting Schedule**

Chair Corzo asked the members to review the various OCC MAC meeting schedules provided. After review of the schedules, the committee asked staff to revise the schedule and return it for approval at the June 27, 2019 meeting.

**Consider Recommendation of OCC MAC Slate of Candidates**

Vice Chair Mouton, reported that the Nominations Ad Hoc Committee met on April 10, 2019 and included OCC MAC member, Keiko Gamez, MAC Chair, Sally Molnar and herself serving on the ad hoc. The Committee reviewed four applications for the five expiring seats and recommended the

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following slate of candidates: Sandy Finestone for the Persons with Disabilities Representative; Sara Lee for the Ethnic or Cultural Community Representative, Mario Parada (new applicant) for the IHSS/Union Provider Representative, Josefina Diaz for one of the OCC Member/Family Member Representative seats and Donald Stukes (new applicant) for the Member Advocate Representative, fulfilling the remaining term, which expires on June 30, 2020. Vice Chair Mouton indicated that recruitment for the remaining OCC Member/Family Member Representative will continue until a candidate has been identified and also mentioned that the Chair and Vice Chair positions will be determined at the same time the new members are seated in August 2019.

***Action:*** ***On motion of Chair Corzo, seconded and carried, the OCC MAC approved the FY 2019-21 Slate of Candidates and the Member Advocate Representative with a term through June 30, 2020. (Motion carried 6-0-0)***

**OCC MAC Member Updates**

Chair Corzo, reported that the OCC MAC is also recruiting to fill the Long-Term Services and Supports Representative seat vacated when Ted Chigaros resigned.

**ADJOURNMENT**

Chair Corzo announced that the next OCC MAC Meeting will be held on Thursday, June 27, 2019 at 3:00 p.m.

Hearing no further business, Chair Corzo adjourned the meeting at 4:37 p.m.

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

*Approved: August 22, 2019*

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# MINUTES

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

**June 13, 2019**

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, June 13, 2019, at the CalOptima offices located at 505 City Parkway West, Orange, California.

**CALL TO ORDER**

Teri Miranti, PAC Vice Chair, called the meeting to order at 8:07 a.m. and Dr. Sweidan led the Pledge of Allegiance.

**ESTABLISH QUORUM**

Members Present: Teri Miranti, Vice Chair; Steve Flood; Junie Lazo-Pearson, Ph.D.; Craig Myers; Mary Pham, Pharm.D., CHC; Jacob Sweidan, M.D.; Dr. Anja Batra (8:16 A.M.); Tina Bloomer, MHNP; Pat Patton, MSN, RN.

Members Absent: Brian Lee, Ph.D.; John Nishimoto O.D., Chair, Donald Bruhns, Theodore Caliendo, M.D, Jena Jensen.

Others Present: Ladan Khamseh, Chief Operating Officer; Michelle Laughlin, Executive Director, Network Operations; Gary Crockett, Chief Counsel; Candice Gomez, Executive Director, Program Implementation; David Ramirez, MD, Chief Medical Officer; Tracy Hitzeman, Executive Director, Clinical Operations; Belinda Abeyta, Executive Director, Operations; Cheryl Simmons, Sr, Program Specialist, Staff to the Advisory Committees, Customer Service; Samantha Fontenot; Program Assistant, Staff to the Advisory Committees, Customer Service.

PAC members welcomed Tina Bloomer, WHNP, as the new Nurse Representative on the PAC. Ms. Bloomer was appointed by the Board at its June 6, 2019 meeting and will fulfill the remaining term of the seat through June 30, 2021. Vice Chair Miranti also updated the PAC on the new Board appointments to the PAC and noted the reappointment of Chair Nishimoto to an additional one-year term as the PAC Chair and herself as the Vice Chair.

**MINUTES**

**Approve the Minutes of the May 9, 2018 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee**

***Action:*** ***On motion of Member Dr. Sweidan, seconded and carried, the Committee approved the minutes of the May 9, 2019 meeting. (Motion***

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***carried 8-0-0; Members Lee, Nishimoto, Bruhns, Caliendo, and Jensen absent)***

**PUBLIC COMMENTS**

There were no requests for public comment

**REPORTS**

**Consider Approval of FY 2018-2019 PAC Accomplishments**
The FY 2018-19 PAC Accomplishments were presented for approval. The accomplishments will be presented as an information item to the CalOptima Board of Directors at their August 1, 2019 meeting.

*Action:* ***On motion of Member Dr. Sweidan, seconded and carried, the Committee approved the minutes of the May 9, 2019 meeting. (Motion carried 8-0-0; Members Lee, Nishimoto, Bruhns, Caliendo, and Jensen absent)***

*Vice Chair Miranti reordered the agenda to hear Information Item VII.A Healthy Smiles Presentation, before continuing on with CEO and Management Reports*

**Healthy Smiles Presentation**
Ria Berger, CEO of Healthy Smiles for Kids of Orange County (and CalOptima Board Member), along with Harvey Lee, DDS, Healthy Smiles' Chief Dental Officer, provided a presentation on the mission of Health Smiles for Kids. Ms. Berger noted that one in three children suffer from tooth decay in Orange County. She explained Healthy Smiles' mission of improving the oral health of children in Orange County through collaborative programs directed at prevention, outreach and education, access to treatment and advocacy. She also estimated that over 100,000 children and parents are reached each year and that Healthy Smiles' goal is to treat one million children by the year 2020.

**CEO & MANAGEMENT REPORTS**

**Chief Operating Officer Update**
Ladan Khamseh, Chief Operating Officer, provided an update on the Whole-Child Model implementation effective July 1, 2019. She noted that transitioning CalOptima members received automated calls from CalOptima providing information about the transition as part of the 30-day notice which has been completed. Ms. Khamseh also provided information on the Homeless Health Initiative, notifying the committee that CalOptima's clinical field teams are now able to provide services six days a week. She noted that an additional Community Health Center, Families Together, had partnered with CalOptima alongside four other Federally Qualified Health Centers (FQHCs) as part of the pilot. Ms. Khamseh discussed how CalOptima will be partnering with various shelters throughout Orange County to increase the referral sources.

Ms. Khamseh mentioned that that the Board of Directors had authorized a contract with Chapman Consulting to assist the Board in formulating the 2020-23 Strategic plan. She also noted there will be regular updates provided to the Advisory Committees and that Chapman Consulting would be reaching out to the advisory committee chairs and vice chairs to schedule 30-minute conference calls with each. A special joint advisory committee meeting will be held on October 10, 2019 to review the strategic plan before submitting to the Board in December 2019.

Ms. Khamseh noted that Proposition 56 (Tobacco Tax) FY 2018-19 payments had been released to the health networks including the CalOptima Care Network (CCN) providers.

**Chief Medical Officer Update**

David Ramirez, M.D., Chief Medical Officer, provided an update on Telehealth, noting that CalOptima is looking forward to receiving an All Plan Letter (APL) from the Department of Health Care Services (DHCS) . Once the APL is received, CalOptima will start the planning and implementation process to increase access and provide more options for CalOptima members. Dr. Ramirez noted that the goal was to eventually integrate the Telehealth program with the member portal. Dr. Ramirez also mentioned that the OneCare and OneCare Connect Behavioral Health services that are currently administered by Magellan Health Care would be transitioning to CalOptima effective January 1, 2020. Dr. Ramirez also noted that CalOptima is submitting the quality measure outcomes to the National Committee for Quality Assurance (NCQA) and that the Health Homes Program will be starting in January 2020.

**Network Operations Update**

Michelle Laughlin, Executive Director, Network Operations, provided a verbal update on CalOptima's finalization of the implementation of the Whole-Child Model Network including the educational outreach to providers, the finalization of the Frequently Asked Questions (FAQs) which was sent out to all the health networks, the California Children Services (CCS) panel providers and hospitals. Ms. Laughlin also noted that CalOptima is in the process of re-contracting for the entire provider network. She noted these contracts are amended and restated contracts for CalOptima's Health Networks and CalOptima is asking that the contracts be signed before the end of June 2019. Additionally, these amendments will include language on Proposition 56 (Tobacco Tax).

**INFORMATION ITEMS**

**Whole-Child Model Update**

Candice Gomez, Executive Director, Program Implementation, and Tracy Hitzeman, Executive Director, Clinical Operations, provided a verbal update on the Whole-Child Model (WCM) Program Implementation. Ms. Hitzeman discussed how the Personal Care Coordinators (PCCs) in the Case Management Department had begun outreach to the WCM families in May in order to conduct Health Needs Assessments (HNA). Ms. Hitzeman noted that over 1,000 calls had been made by the PCCs to WCM families. CalOptima has forwarded the HNA data along with supplemental information to the member's health networks. Ms. Gomez mentioned that CalOptima has been working closely with the health networks to make sure that their desktop

policies and procedures are updated. She also noted that CalOptima's Provider Relations department has been providing outreach to high volume CCS providers to insure a cohesive transition with provider claims and referrals.

**Case Management Update**
Tracy Hitzeman, Executive Director, Clinical Operations, and Sloane Petrillo, Director, Case Management, presented on Case Management's role in the Homeless Health Initiative . She noted that CalOptima has also partnered with various health networks in coordination with the County's Outreach and Engagement staff (Blue Shirts) and the FQHCs' Clinical Field teams to offer recuperative care placement for homeless individuals who meet medical criteria. Ms. Hitzeman reiterated to the PAC that CalOptima's role is to provide support and promote engagement between the County's Outreach and Engagement Team, Public Health Nurses, Case Management, and the FQHCs' clinical field teams.

**PAC Member Updates**
Vice Chair Miranti announced that at the June 6, 2019 Board of Directors meeting, the Board appointed the PAC recommended slate of candidates apart from a seat for a Long-Term Services and Supports Representative. She noted the PAC will need to reconvene the existing nominations ad hoc committee to review the open seat as per the Board's direction. The original ad hoc consisted of Members Myers, Pham and Sweidan. Member Pham's term with the PAC has ended and Member Batra agreed to replace her on the ad hoc.

Vice Chair Miranti also noted that an additional ad hoc needed to be formed consisting of Chair Nishimoto and two members to review and revise the recruitment process for all of the Advisory Committees. The ad hoc would work in conjunction with the Member Advisory Committee (MAC) and the OneCare Connect Member Advisory Committee (OCC MAC). In addition to Chair Nishimoto, Vice Chair Miranti and Member Lazo-Pearson volunteered to be part of this ad hoc.

**ADJOURNMENT**

There being no further business, Vice Chair Miranti adjourned the meeting at 10:01 a.m.

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

***Approved: August 8, 2019***

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# MINUTES

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

June 13, 2019

A Special Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on June 13, 2019, at CalOptima, 505 City Parkway West, Orange, California.

**CALL TO ORDER**

Chair Sally Molnar called the meeting to order at 2:27 p.m. and Christine Tolbert led the Pledge of Allegiance.

**ESTABLISH QUORUM**

Members Present: Sally Molnar, Chair; Patty Mouton, Vice Chair; Suzanne Butler (2:35 pm);Sandra Finestone; Diana Cruz-Toro; Connie Gonzalez; Jaime Munoz (2:42 pm); Pamela Pimentel (2:46 pm); Sr. Mary Therese Sweeney; Christine Tolbert; Jacquelyn Ruddy

Members Absent: Mallory Vega; Ilia Rolon

Others Present: Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Candice Gomez, Executive Director, Program Implementation; Belinda Abeyta, Executive Director, Operations; Tracy Hitzeman, Executive Director, Clinical Operations; Mauricio Flores, Manager, Customer Service; Cheryl Simmons, Staff to the Advisory Committees, Customer Service; Samantha Fontenot, Program Assistant, Customer Service

**MINUTES**

**Approve the Minutes of the March 14, 2019 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee**

*Action:* ***On motion of Member Sandra Finestone, seconded and carried, the MAC approved the minutes as submitted. (8-0-0, Members Butler, Munoz, Pimentel, Rolon and Vega absent)***

**PUBLIC COMMENT**

There were no requests for Public Comment.

**REPORTS**

**Consider Approval of FY 2019-2020 Member Advisory Committee Meeting Schedule**

MAC members reviewed the proposed FY 2019-20 meeting schedule. As proposed the MAC would meet on a bi-monthly basis the second Thursday of the month starting on August 8, 2019.

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*Action:* ***On motion of Member Finestone, seconded and carried, the Committee approved the FY 2019-20 Meeting Schedule. (Motion carried 9-0-0, Members Munoz, Pimentel, Rolon and Vega absent)***

**Consider Approval of FY 2018-19 MAC Accomplishments**

The FY 2018-19 MAC Accomplishments were presented for approval.

*Action:* ***On motion of Member Sandra Finestone, seconded and carried, the Committee approved the FY 2018-19 MAC Accomplishments. (Motion carried 10-0-0, Members Pimentel, Rolon and Vega absent)***

**Consider Recommendation of Member Advisory Committee Slate of Candidates**

Member Tolbert presented the recommendations on behalf of the MAC Nominations Ad Hoc Committee which also consisted of Members Gonzalez and Ruddy. The ad hoc met on May 22, 2019, via conference call to review the applicants to fill six expiring seats. The ad hoc reviewed six incumbent applicants for the open seats and the following reappointments were recommended: Patty Mouton, Medi-Cal Beneficiaries Representative, Sandra Finestone, Adult Beneficiaries Representative, Ilia Rolon, Family Support Representative, Suzanne Butler, Persons with Disabilities Representative, Diana Cruz-Toro, Recipients of CalWORKs Representative and Mallory Vega, Seniors Representative.

*Action:* ***On motion of Member Sr. Mary Therese Sweeney, seconded and carried, the Committee approved the Recommendation of the Slate of Candidates. (Motion carried 10-0-0, Members Pimentel, Rolon and Vega absent)***

## CEO AND MANAGEMENT REPORTS

**Chief Operating Officer Update**

Ladan Khamseh, Chief Operating Officer (COO), provided a verbal update on the Whole-Child Model (WCM) implementation July 1, 2019. She noted that transitioning CalOptima members received robo calls as part of the 30-day notice which has been completed. Ms. Khamseh also provided information on the Homeless Health Initiative that would include partnering with various shelters throughout Orange County to increase the referral sources.

Ms. Khamseh mentioned that the Board of Directors' authorized CalOptima to contract with Chapman Consulting, LLC to help facilitate the FY 2020-2022 Strategic Planning Session. She noted that Chapman Consulting will be reaching to the Chair and Vice Chair of each of the Advisory Committees to schedule a 30-minute interview to gain their perspective with regard to the next three years. A special joint advisory committee meeting will be held on October 10, 2019 where Chapman Consulting will review the 2020-2022 strategic plan with the advisory committees.

Ms. Khamseh noted that Proposition 56 (Tobacco Tax) FY 2018-2019 payments had been released to the health networks including the CalOptima Care Network (CCN) providers.

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**Chief Medical Officer Update**

David Ramirez, M.D., Chief Medical Officer (CMO), provided an update on Telehealth noting that CalOptima is waiting on the All Plan Letter (APL) from the Department of Health Care Services (DHCS) . Once the APL is received, CalOptima will start the planning and implementation process to increase access and provide more options for CalOptima members. Dr. Ramirez noted that the goal was to eventually integrate the Telehealth program with the member portal. Dr. Ramirez informed the committee that the OneCare and OneCare Connect Behavioral Health Services currently administered by Magellan Health Care will transition to CalOptima starting January 1, 2020. Dr. Ramirez also informed the Committee that CalOptima will be submitting the quality measure outcomes to the National Committee for Quality Assurance (NCQA) and the Health Homes Program will begin on January 1, 2020.

**INFORMATION ITEMS**

**Whole-Child Model Update**

Candice Gomez, Executive Director, Program Implementation and Tracy Hitzeman, Executive Director, Clinical Operations, provided a verbal update on the Whole-Child Model (WCM) program implementation. Ms. Gomez noted CalOptima's Provider Relations department has been providing outreach to high volume CCS providers to insure a cohesive transition with provider claims and referrals.

Ms. Hitzeman discussed the outreach to WCM families currently being completed by CalOptima's Personal Care Coordinators (PCCs) in order to conduct Health Needs Assessments (HNA). Ms. Hitzeman noted that over 1,000 calls had been made by the PCC's to the WCM families. CalOptima has forwarded the HNA data along with supplemental information to the member's health networks.

**Case Management Presentation**

Tracy Hitzeman, Executive Director, Clinical Operations, presented on Case Management's role in the Homeless Health Initiative. She noted that CalOptima has partnered with various health networks in coordination with the County's Blue Shirts and FQHCs Clinical Field teams to offer recuperative care placement for homeless individuals. Ms. Hitzeman reiterated to the MAC that CalOptima's role is to provide support and promote engagement between the County's outreach and engagement team, public health nurses, Case Management, and the FQHC's clinical field teams.

**Member Portal Demonstration**

Mauricio Flores, Manager, Customer Service, provided a demonstration on the CalOptima Member Portal.

**MAC Member Updates**

Chair Molnar notified the committee that an ad hoc committee would be formed to review and revise the recruitment process that would include committee members from the OneCare Connect Member Advisory Committee and the Provider Advisory Committee. This ad hoc would include the new FY 2019-20 MAC Chair and two MAC members. Vice Chair Patty Mouton and Member Pamela Pimentel volunteered to be part of this ad hoc. Chair Molnar also noted the MAC still has

an open seat for a Long-Term Services and Supports Representative and recruitment remains open for this seat.

Chair Molnar notified the committee that if they were interested in becoming the Committee Chair or Vice Chair for 2019-20 to please email Cheryl Simmons with a brief summary of their qualifications to be the chair or vice chair.

**ADJOURNMENT**

Chair Molnar announced that the next MAC meeting is scheduled for Thursday, August 8, 2019 at 2:30 p.m.

Hearing no further business, Chair Molnar adjourned the meeting at 4:31 p.m.

*/s/ Cheryl Simmons*

Cheryl Simmons
Staff to the Advisory Committees

***Approved: August 8, 2019***

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken September 5, 2019**
**Regular Meeting of the CalOptima Board of Directors**

**Consent Calendar**

3. Consider Authorizing Changes to Allowable Rates for Services Provided by Nurse Practitioners and Physician Assistants at the Program of All-Inclusive Care for the Elderly (PACE) Clinic

**Contact**

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

**Recommended Action**

Authorize the Chief Executive Officer (CEO) to update the table of allowable rates for services provided by Nurse Practitioners and Physician Assistants at the PACE clinic

**Background**

PACE is a Medicare and Medicaid managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima opened its PACE center on October 1, 2013, and currently serves approximately 346 members via the CalOptima PACE center and five operating alternative care settings.

At its August 1, 2019 meeting, the CalOptima Board of Directors authorized minimum and maximum allowable hourly provider rates in response to market conditions and to expand the availability of medically necessary services provided in the PACE clinic. A table by provider type was included as a guide to the allowable hourly rates.

**Discussion**

In the table presented at the August 1, 2019 meeting, Mid-level Physician Assistants (PAs) and Nurse Practitioners (NPs) were incorrectly included in the category established for Medical Doctors (MDs) and Doctors of Osteopathy (DOs) who provide primary care services. Though PAs and NPs have regulatory approval to serve as "Primary Care Providers" there is a significant difference in the training and scope of practice between physicians and mid-level practitioners. To address this issue, Staff recommends that the categories be adjusted to align compensation with scope of practice as listed in the following table:

| PROVIDER TYPE | Min. Hourly Rate | Max. Hourly Rate |
|---|---:|---:|
| Primary Care Physician – MD, DO | $140.00 | $250.00 |
| Ancillary Provider, Speech Therapy, PA, NP, and Licensed Clinical Social Worker | $90.00 | $150.00 |
| Dermatology, Endocrinology, Neurology, Pain Medicine, Psychiatry, Rheumatology, and other physician specialist as required | $150.00 | $300.00 |
| Medical Director | $150.00 | $300.00 |

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CalOptima PACE employs a Medical Director for oversight of PACE medical services and health plan functions, including grievances, appeals, quality initiatives, utilization management and oversight of medical services rendered. When this Medical Director's allocated time dedicated to the PACE program decreased to less than 0.5 FTE, and the administrative needs increased with the expansion of the program, a contracted physician assigned to the PACE clinic was allocated weekly administrative hours to support the clinical operations decision-making required, under the oversight of the CalOptima PACE Medical Director. To date, the physicians fulfilling a Clinic Medical Director role have been contracted, including a provider from the University of California-Irvine (UCI) Department of Family Medicine Division of Geriatric Medicine and Gerontology. This contract is scheduled to terminate October 31, 2019. Staff is working with an external recruiter to secure a new Clinic Medical Director contractor. Once identified, the contracted Clinic Medical Director will be compensated within the range indicated in the table above would be eligible for participation in the Board-approved PACE provider incentive plan.

**Fiscal Impact**

The recommended action to adjust the minimum and maximum allowable hourly rate for mid-level Nurse Practitioners and Physician Assistant at the PACE Clinic is budget neutral. Funding for the estimated increase to medical costs is within the CalOptima Fiscal Year 2019-20 Operating Budget.

**Rationale for Recommendation**

Staff proposes that the Board authorize update to the hourly rate ranges for professional medical services provided at the PACE center. An adjustment is required to align the PA and NP providers under the appropriate category based on their training and scope of practice.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

1. Board Action dated June 5, 2007, Authorize the CEO to Negotiate Rates for Certain FFS Contracts
2. Board Action dated September 7, 2017. Authorize an Amendment to Physician Services Contract for PACE
3. Board Action dated August 1, 2019, Authorize CEO to Negotiate Rates for Certain FFS Contracts for PACE

*/s/ Michael Schrader* *8/28/19*

**Authorized Signature** **Date**

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# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken June 5, 2007**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**
VI. B. Authorize the Chief Executive Officer to Negotiate Rates for Certain Fee-for-Service Contracts for Health Care Services

**Contact**
Gregory Buchert, M.D., MPH, Chief Operating Officer, (714) 246-8400

**Recommended Action**
Authorize the CalOptima Chief Executive Officer (CEO) or his designee, to negotiate rates for certain fee-for-service (FFS) contracts within budget and rate guidelines and regulatory requirements.

**Background**
CalOptima has implemented several different contracting models for health care services for its lines of business. The CalOptima Direct (COD) network includes fee-for-service hospital contracts as well as some limited ancillary services contracts (e.g., wheelchairs). The CalOptima OneCare program includes physician shared risk contracts and other contracted hospitals and ancillary providers. At present the delivery system for the Medi-Cal and Healthy Families programs is primarily through capitated health networks. CalOptima needs to be able to negotiate best pricing for physicians, hospitals, ancillary and other services as well as secure access to services. In order to do so, CalOptima seeks authority to enter into negotiated fee-for-service contracts.

**Discussion**
CalOptima is building a contracted provider network to support the medical needs of all of our members in each of our product lines that is both budget based and medically appropriate. The building of this network is required to have a full scope, qualified provider panel for all of our members and to be able to effectively manage the health care needs for our diverse population including the very young, the very old, and the medically fragile and vulnerable.

CalOptima requires a network of credentialed, quality providers to support our members' medical needs. CalOptima needs to contract with providers using appropriate fee schedules and will base the payment on the product line and current product line rates, but there will be periodic needs to deviate from these rates for issues of access and availability. The fee-for-service agreements will create a provider network both within Orange County and outside of the County, as needed, to support the covered services.

The following guidelines will apply to negotiated fee-for-service contracts:

- When appropriate to access best pricing or access to services, CalOptima may enter into negotiated fee-for service contracts for identified items and services.
- CalOptima will continue to use standard medical service agreements based on product lines and provider types, with assistance of legal counsel, but may negotiate reimbursement terms.
- Negotiated fee-for-service contracts will not be sought for services to members where CalOptima has subcapitated financial risk for the items and/or services to a provider (e.g., Medi-Cal PHC contracts, Medi-Cal and Medicare shared risk contracts), but CalOptima will encourage contracted parties to extend the same terms, rates and conditions to its subcapitated entities.
- Rates will be negotiated within the guidelines below. Any rate in excess of 150% of the fee schedule will require approval from the CEO or designee.

Rate Summary:

| Situation | Payment Rate |
|---|---|
| Routine services including ancillary services | Contract with rates at or below the fee schedule |
| Difficult to access services meeting predetermined access criteria | Contract with the minimally mutually agreeable rates < 150% of the fee schedule |
| Rare, one time situations where provider is unwilling to contract at available rates | One time Letter of Agreement for a specified service for a specific patient |

**Fiscal Impact**
The recommended action to negotiate rates for fee-for-service contracts for certain health care services will use approved contract boilerplate agreements and budget based payment schedules. These costs have been included in budget projections for 2008.

**Rationale for Recommendation**
CalOptima must be responsive and adaptive to opportunities to secure ancillary items and services based on best pricing and to secure access to providers where such access may be limited. While the goal is to contract as many providers as possible within the standard fee schedules, it is necessary to have the contracting flexibility in these situations.

**Concurrence**
Procopio, Cory, Hargreaves & Savitch LLP

**Att chments**
None

Richard Chambers
**Authorized Signature**

5/31/07
**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**

12. Specific to the CalOptima PACE Program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services

**Contact**

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

**Recommended Actions**

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an amendment of the Program of All Inclusive Care (PACE) contract between CalOptima and the Regents of the University of California on behalf of the University of California Irvine, School of Medicine, Geriatric Program (UCI) for physician and non-physician medical practitioner (NPMP) services to amend the scope of work, compensation terms, and to add an incentive program, upon regulatory approval.
2. Establish maximum hourly rates for PACE Physician and Non-physician Providers.
3. Authorize the implementation of an incentive program for UCI PACE PCP services, in accordance with the attached CalOptima PACE PCP Incentive Program Grid, subject to any necessary regulatory agency approval.
4. Authorize contracting with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE.

**Background**

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent participants from unnecessarily being confined to an institution and to maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents

The PACE program requires that a number of services are provided at a PACE Center. The Center is a medically-intensive care coordination facility that provides a number of services, including Primary Care, to participants.

At the November 3, 2011 Board of Directors Meeting, Staff received authorization to enter into new provider and vendor contracts as necessary for the operation of PACE. CalOptima subsequently executed a contract with UCI to provide Primary Care services at the PACE center effective March 15, 2013 ("Contract"). Compensation to UCI for this service is on an hourly basis. Subsequently, the Contract was amended in October of 2013 to add on-call services and in December of 2013 to revise

the hourly rate. In July 2014, the Contract was amended to revise the hourly rate and to add an hourly rate for non-physician medical practitioners (NPMPs).

UCI's Department of Family Medicine Division of Geriatric Medicine and Gerontology has provided Primary Care services to PACE since the opening of the Center. The Department not only provides expertise in geriatric medicine but also a significant amount of staffing depth with currently eleven faculty members. It also provides the opportunity for geriatric fellows and residents to experience care in a PACE setting. This is positive for UCI in attracting fellows, resident and faculty. It is a benefit for Orange County in that physicians often remain in the area where they train. And it is a benefit for CalOptima PACE in that members receive care from practitioners dedicated to this population and who are up to date on current trends in geriatrics. The relationship between the parties has been positive and mutually beneficial. Staff wishes to continue its relationship with UCI.

**Discussion**

UCI Compensation: At the inception of the Primary Care contract with UCI, Staff negotiated an hourly rate for the provision of services. UCI only receives compensation for services rendered. Although Staff received authorization to complete a contract for Primary Care services at the November 3, 2011 Board meetingThe method of compensation is in the form of an hourly rate for the services of physicians and NPMPs. On-call services are contracted on a per on-call period. On-call periods are based on the non-PACE Center hours during Monday - Friday (4:30 p.m. to 8:00 a.m.) and per day on weekends and holidays (8:00 a.m. to 8:00 a.m.).

UCI has notified CalOptima of a need to increase the hourly rates it receives for the provision of services to the PACE Center. The costs associated with the provision of services by UCI have increased. In addition, staff is recommending contracting with additional providers of primary care services to provide appropriate coverage for the ongoing operation of PACE (see below). It is recommended that the Board establish a maximum hourly rate for PACE physician and non-physician services, and authorize staff to enter into appropriate contracts at rates up to the Board-established maximum. Staff is recommending a maximum rate for physician services of $200.00 per hour, and a maximum rate for non-physician primary care services of $130.00 per hour. The actual rates within the allowable range would be set based on the provider's training, experience, and other resources brought to the provision of the services at the PACE Center (e.g., UCI has requested to provide additional services using Fellows and residents at no cost to CalOptima).

UCI Incentives: Staff requests authorization to add an incentive program for UCI at PACE to focus on increasing patient satisfaction; increasing accuracy of documentation of participant care; and reducing inappropriate inpatient admissions. Please note that the implementation of the incentive plan is subject to regulatory approvals. A detailed grid of the proposed program is attached to this COBAR.

- Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with the medical care provided at the PACE center. Participant medical care and overall

satisfaction with PACE are measured. UCI is eligible to receive an incentive based on a 90% or higher participant satisfaction score.

- Physician documentation of patient care is essential the delivery of quality care and insures appropriate payment from State and federal entities. CalOptima Staff, using audit processes that align with industry standards, will audit physician documentation biannually. UCI will receive additional compensation based on positive results of the audit as reflected on the attached grid.

- As the primary care provider for PACE participants, UCI primary care providers are essential in appropriately assessing a participant's condition and avoiding unnecessary inpatient admissions. Participation in the concurrent review process helps prevent under and over utilization of services. Assisting in the transition of care for a participant from an acute care setting assures the member will continue to receive the care they need and will reduce readmissions. If successful in reducing bed days per thousand per year to the levels identified in the incentive grid attached, UCI will be eligible for a portion of the savings attributed to inpatient costs for PACE. The target bed days per thousand per year are based on CalPACE benchmarks.

Revision to the Scope of Work: Staff requests authority to revise the scope of work to modify responsibilities and qualifications of the physician and NPMP rendering Primary Care services and add responsibilities for UCI to provide clinical Medical Director services. UCI may incorporate care provided by Fellows and residents at the PACE clinic, under the condition that these services are overseen by an onsite contracted UCI physician. The Fellows and residents will be provided at no cost to CalOptima and will enhance the number of providers rendering services at the PACE center.

Updating of Contract Form: In addition to the above changes, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract also be included.

Additional Authority to Contract: Staff requests authority to contract with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE. Additional providers include, but are not limited to, local Primary Care physicians, Locum Tenens and NPMPs. These providers will be paid at the CalOptima fee schedule.

**Fiscal Impact**

The recommended action to revise the rate paid to UCI effective September 1, 2017 through June 30, 2018, modify the compensation methodology for on-call services, and implement an incentive payment program is an unbudgeted item. Based on current utilization, funding for the recommended action will increase medical expenses by $80,000, thereby reducing budgeted income for the PACE program to

$131,373 for Fiscal Year 2017-18. Management will include updated PACE medical expenses in future operating budgets.

**Rationale for Recommendation**
CalOptima staff recommends this action to maintain the contractual relationship with UCI for the provision of Primary Care services to CalOptima PACE and to ensure coverage of Primary Care services for PACE.

**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**
1. Board Action dated November 3, 2011, Authorize the Chief Executive Office to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE.
2. CalOptima PACE PCP Incentive Program Grid

*/s/ Michael Schrader* — *9/1/2017*
**Authorized Signature** — **Date**

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# CalOptima Board Action Agenda Referral

**Action To Be Taken November 3, 2011**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**

VI. B. Authorize the Chief Executive Officer (CEO) to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE

**Contact**

Peerapong Tantameng, Manager, PACE (714) 246-8400

**Recommended Action**

Authorize the CEO, with the assistance of legal counsel, to amend existing medical provider and administrative support vendor contracts to include PACE, and to enter into new medical provider and administrative support vendor contracts as necessary for operation of PACE within the parameters of the Board-approved operating budget.

**Background**

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program will be the first PACE program offered to Orange County residents. Also, CalOptima will be the first County Organized Health System to offer a PACE program to its members.

The hub of a PACE program is the PACE Center, a medically-intensive care coordination facility that provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide a full range of necessary services outside of the PACE Center setting to ensure the proper continuum of care, including, but not limited to:

- Transportation to the PACE center and to medical appointments
- Skilled and personal home care
- Inpatient, outpatient, and specialty care
- Nursing home care, both short and long-term
- Home-delivered meals
- Durable medical equipment

**Discussion**

On October 7, 2010, the CalOptima Board of Directors authorized the CEO to submit CalOptima's PACE application to the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). At that time, staff committed to returning to Board to obtain authority to implement operational items for PACE and which are

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required by federal and state regulations, including the execution of contracts with the necessary providers and vendors, many of which are subject to state licensure requirements, to adequately serve CalOptima members who enroll in PACE.

CalOptima staff now seeks authority to amend existing agreements and enter into new agreements with providers and vendors, subject to regulatory approval of CalOptima's PACE program, to offer the necessary medical, social, and community-based services required of a PACE program, including but not limited to the following types of medical providers and administrative support vendors:

- Medical Director;
- PACE Center-based practitioners, including the primary care physician and rehabilitation therapists;
- Medical specialists for the PACE provider network;
- Hospitals;
- Ancillary health services, including dental, audiology, optometry, podiatry, speech therapy, and behavioral health;
- Nursing facilities, for both acute and long-term care;
- Laboratory services;
- Durable medical equipment;
- Home care and home health;
- Transportation;
- Meal service; and
- Electronic Health Record system

Fortunately, many of the provider network needs for PACE can be addressed by amending contracts with providers within the designated PACE service area who are already contracted with CalOptima under its other lines of business. While provider and vendor contracts must include certain regulatory terms that are required by DHCS and CMS, many of these terms are similar to those required for CalOptima's current Medi-Cal and OneCare programs. However, because CalOptima will be a new entrant into the PACE program, staff anticipates that, within the bounds of regulatory and budgetary limitations, there may be a need for variations among agreements based upon the type of provider or vendor, PACE regulatory requirements, and unique institutional requirements that providers or vendors may have in finalizing CalOptima agreements. Staff's proposed strategy is to approach providers and vendors with uniform sets of terms and conditions to minimize the number and scope of variances between contracts. Staff will update the Board of Directors on the progress of the contracting efforts as they move forward.

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**Fiscal Impact**

It is anticipated that the amendments and new contracts to be negotiated with medical providers and vendors for administrative services will be consistent with the projected expenses reflected in the operational budget for PACE approved by the Board on June 2, 2011.

**Rationale for Recommendation**

As a new entrant to the PACE market and given the tight timeline for bringing up the PACE program, CalOptima will need to both amend contracts with existing medical providers and administrative support vendors, as well as enter into agreements with new medical providers and administrative support vendors. Through this process, staff plans to put in place the various contractual relationships that are necessary for the proper operation of the CalOptima PACE program.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

| *_/s/ Richard Chambers_* | *_10/28/11_* |
|---|---|
| **Authorized Signature** | **Date** |

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## CalOptima PACE PCP Incentive Program

| Measure | Background | Time Period | Time of Measurement | Metric Detail | Scoring | Amount | Payment |
|---|---|---|---|---|---|---|---|
| Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care | PCP's are important component of the medical team which provides care to the participants at the PACE center. | CY | CY Q4 | Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score* | <90% | $0 PMPM | April |
| | | | | | >/= 90% | $1 PMPM | April |
| Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction | Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE. | CY | CY Q4 | Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score** | < 90% | $0 PMPM | April |
| | | | | | >/= 90% | $1 PMPM | April |
| Coding Accuracy Rate | Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis. | CY | Biannually | The CalOptima Coding Department will audit charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits. | <75% | $0 PMPM | April |
| | | | | | 75-89% | $0.5 PMPM | April |
| | | | | | >/= 90% | $1 PMPM | April |
| CalOptima PACE Actual Inpatient Performance | Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP. | CY for 1st 6 Months of 2018 | Audited CY Performance for the 1st 6 Months of 2018 | PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016. | Incentive Begins at BD / K / Y equivalent of 2,300 | Total potential: $19.30 PMPM or ~ $30,000*** | October, 2018 |
| | | | | | Incentive ends at BD / K / Y equivalent of 2,000 | | |
| | | FY Starting July 1st, 2018 | Audited FY Performance | Will be determined by budget and CalPACE updated averages | TBD | TBD | October, 2019 |
| | | | | | TBD | TBD | |

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.
*** Potential incenitve was estimated based on the projected member months from January, 2018 to June, 2018.

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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**

4. Consider Authorizing the Chief Executive Officer to Negotiate Rates for Certain Fee-for-Service and Clinic Provider Contracts for CalOptima Program of All-Inclusive Care for the Elderly (PACE)

**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 negotiate rates for certain fee-for-service (FFS) and PACE clinic provider contracts, within budget and rate guidelines and regulatory requirements.

*Rev. 8/1/19*

**Background**

PACE is a Medicare and Medicaid managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima opened its PACE center on October 1, 2013, and currently serves approximately 325 members via the CalOptima PACE center and five operating alternative care settings.

CalOptima has implemented several different contracting models for its lines of business. In a June 5, 2017 COBAR, the Board authorized guidelines for certain fee-for-service contracts with the rationale that CalOptima must be responsive and adaptive to opportunities to secure services based on best pricing and to secure access to providers where such access may be limited. While the goal was, and still remains, to contract adequate numbers of providers within standard fee schedules, it is necessary to have contracting flexibility in certain situations.

**Discussion**

CalOptima PACE utilizes providers for primary care and specialist services rendered in the PACE center. In September 7, 2017, the Board authorized a maximum hourly rate of $200 for PACE physicians and $130 for non-physician primary care services for center-based services. Staff recommends increasing the maximum allowable rate to up to $300 per hour for providers to ensure competitive rates to continue to contract with needed PACE providers and to allow PACE to utilize the hourly rate payment model to contract with physician specialists. In addition to primary care, behavioral health and an on-site clinical medical director, CalOptima PACE will contract utilizing up to the maximum allowable rate for on-site specialist services at the PACE center including but not limited to endocrinology, rheumatology, pain management, neurology, dermatology, psychiatry, speech therapy and other ancillary services. .
Hourly rates also give PACE the mechanism to reimburse specialists for attending PACE Interdisciplinary Team (IDT) meetings which is vital to the PACE Model of Care, improving quality and coordination.

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All the physicians who are approaching or at the $200 maximum allowable rate are PCPs. Currently, PACE has been unable to contract with specialists at an hourly rate, as most physician specialists are reimbursed in the $225 to $300 range. This range varies and the actual rates within the allowable range will be set based on the provider's training, specialty and experience. In addition to over five years of direct experience with the demands of operating a PACE clinic, staff recommendation is based on consultation from a provider staffing group specializing in the Southern California market. The group asserts that provider services in 2019, including primary care, clinic medical director, behavioral health, LCSWs and other specialists, range from an hourly rate of $110 to $300. To meet the demands of the market, staff recommend an increase in the maximum allowable rate at this time to maintain and expand medically necessary provider contracts for primary care, specialty and ancillary services provided in the PACE clinic, within the rate ranges listed in the following table.

| PROVIDER TYPE | Min. Hourly Rate | Max. Hourly Rate |
|---|---|---|
| Primary Care Providers – MD, DO, NP, PA | $140.00 | $250.00 |
| Ancillary Providers, Speech Therapy and Licensed Clinical Social Workers | $90.00 | $150.00 |
| Dermatology, Endocrinology, Neurology, Pain Medicine, Psychiatry, Rheumatology, and other physician specialists as required. | $150.00 | $300.00 |
| Medical Director | $150.00 | $300.00 |

CalOptima PACE requires a network of community based, credentialed, quality providers to support PACE participants' medical needs. CalOptima PACE will contract with providers using appropriate fee schedules, with payment based on the product line and current product line rates, but there will be periodic needs to deviate from these rates to maintain adequate and necessary access and availability. To this end, Contracting may negotiate rates up to 150% of the Medicare fee schedule for unique and hard to access services rendered to PACE members. Any rate in excess of 150% of the Medicare fee schedule requires additional approval from the Board.

## Fiscal Impact

The recommended action to negotiate rates for certain FFS and PACE provider contracts is budget neutral. Funding for the estimated increase to medical costs is within the CalOptima Fiscal Year 2019-20 Operating Budget.

## Rationale for Recommendation

CalOptima PACE must be responsive and adaptive to opportunities to secure medically necessary services for PACE participants, based on the Board-approved budget and best pricing, to secure access where such access may be limited.

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**Concurrence**
Gary Crockett, Chief Counsel

**Attachment**
1. Board Action dated June 5, 2007, Authorize CEO to Negotiate Rates for Certain FFS Contracts
2. Board Action dated September 7, 2017, Authorize an Amendment to Physician Services Contract for PACE

*/s/ Michael Schrader* *7/24/19*
**Authorized Signature** **Date**

# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken June 5, 2007**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**
VI. B. Authorize the Chief Executive Officer to Negotiate Rates for Certain Fee-for-Service Contracts for Health Care Services

**Contact**
Gregory Buchert, M.D., MPH, Chief Operating Officer, (714) 246-8400

**Recommended Action**
Authorize the CalOptima Chief Executive Officer (CEO) or his designee, to negotiate rates for certain fee-for-service (FFS) contracts within budget and rate guidelines and regulatory requirements.

**Background**
CalOptima has implemented several different contracting models for health care services for its lines of business. The CalOptima Direct (COD) network includes fee-for-service hospital contracts as well as some limited ancillary services contracts (e.g., wheelchairs). The CalOptima OneCare program includes physician shared risk contracts and other contracted hospitals and ancillary providers. At present the delivery system for the Medi-Cal and Healthy Families programs is primarily through capitated health networks. CalOptima needs to be able to negotiate best pricing for physicians, hospitals, ancillary and other services as well as secure access to services. In order to do so, CalOptima seeks authority to enter into negotiated fee-for-service contracts.

**Discussion**
CalOptima is building a contracted provider network to support the medical needs of all of our members in each of our product lines that is both budget based and medically appropriate. The building of this network is required to have a full scope, qualified provider panel for all of our members and to be able to effectively manage the health care needs for our diverse population including the very young, the very old, and the medically fragile and vulnerable.

CalOptima requires a network of credentialed, quality providers to support our members' medical needs. CalOptima needs to contract with providers using appropriate fee schedules and will base the payment on the product line and current product line rates, but there will be periodic needs to deviate from these rates for issues of access and availability. The fee-for-service agreements will create a provider network both within Orange County and outside of the County, as needed, to support the covered services.

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The following guidelines will apply to negotiated fee-for-service contracts:

- When appropriate to access best pricing or access to services, CalOptima may enter into negotiated fee-for service contracts for identified items and services.
- CalOptima will continue to use standard medical service agreements based on product lines and provider types, with assistance of legal counsel, but may negotiate reimbursement terms.
- Negotiated fee-for-service contracts will not be sought for services to members where CalOptima has subcapitated financial risk for the items and/or services to a provider (e.g., Medi-Cal PHC contracts, Medi-Cal and Medicare shared risk contracts), but CalOptima will encourage contracted parties to extend the same terms, rates and conditions to its subcapitated entities.
- Rates will be negotiated within the guidelines below. Any rate in excess of 150% of the fee schedule will require approval from the CEO or designee.

Rate Summary:

| Situation | Payment Rate |
|---|---|
| Routine services including ancillary services | Contract with rates at or below the fee schedule |
| Difficult to access services meeting predetermined access criteria | Contract with the minimally mutually agreeable rates < 150% of the fee schedule |
| Rare, one time situations where provider is unwilling to contract at available rates | One time Letter of Agreement for a specified service for a specific patient |

**Fiscal Impact**
The recommended action to negotiate rates for fee-for-service contracts for certain health care services will use approved contract boilerplate agreements and budget based payment schedules. These costs have been included in budget projections for 2008.

**Rationale for Recommendation**
CalOptima must be responsive and adaptive to opportunities to secure ancillary items and services based on best pricing and to secure access to providers where such access may be limited. While the goal is to contract as many providers as possible within the standard fee schedules, it is necessary to have the contracting flexibility in these situations.

**Concurrence**
Procopio, Cory, Hargreaves & Savitch LLP

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**Att chments**
None

Richard Chambers
**Authorized Signature**

5/31/07
**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**

12. Specific to the CalOptima PACE Program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services

**Contact**

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

**Recommended Actions**

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an amendment of the Program of All Inclusive Care (PACE) contract between CalOptima and the Regents of the University of California on behalf of the University of California Irvine, School of Medicine, Geriatric Program (UCI) for physician and non-physician medical practitioner (NPMP) services to amend the scope of work, compensation terms, and to add an incentive program, upon regulatory approval.
2. Establish maximum hourly rates for PACE Physician and Non-physician Providers.
3. Authorize the implementation of an incentive program for UCI PACE PCP services, in accordance with the attached CalOptima PACE PCP Incentive Program Grid, subject to any necessary regulatory agency approval.
4. Authorize contracting with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE.

**Background**

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent participants from unnecessarily being confined to an institution and to maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents

The PACE program requires that a number of services are provided at a PACE Center. The Center is a medically-intensive care coordination facility that provides a number of services, including Primary Care, to participants.

At the November 3, 2011 Board of Directors Meeting, Staff received authorization to enter into new provider and vendor contracts as necessary for the operation of PACE. CalOptima subsequently executed a contract with UCI to provide Primary Care services at the PACE center effective March 15, 2013 ("Contract"). Compensation to UCI for this service is on an hourly basis. Subsequently, the Contract was amended in October of 2013 to add on-call services and in December of 2013 to revise

the hourly rate. In July 2014, the Contract was amended to revise the hourly rate and to add an hourly rate for non-physician medical practitioners (NPMPs).

UCI's Department of Family Medicine Division of Geriatric Medicine and Gerontology has provided Primary Care services to PACE since the opening of the Center. The Department not only provides expertise in geriatric medicine but also a significant amount of staffing depth with currently eleven faculty members. It also provides the opportunity for geriatric fellows and residents to experience care in a PACE setting. This is positive for UCI in attracting fellows, resident and faculty. It is a benefit for Orange County in that physicians often remain in the area where they train. And it is a benefit for CalOptima PACE in that members receive care from practitioners dedicated to this population and who are up to date on current trends in geriatrics. The relationship between the parties has been positive and mutually beneficial. Staff wishes to continue its relationship with UCI.

## Discussion

UCI Compensation: At the inception of the Primary Care contract with UCI, Staff negotiated an hourly rate for the provision of services. UCI only receives compensation for services rendered. Although Staff received authorization to complete a contract for Primary Care services at the November 3, 2011 Board meetingThe method of compensation is in the form of an hourly rate for the services of physicians and NPMPs. On-call services are contracted on a per on-call period. On-call periods are based on the non-PACE Center hours during Monday - Friday (4:30 p.m. to 8:00 a.m.) and per day on weekends and holidays (8:00 a.m. to 8:00 a.m.).

UCI has notified CalOptima of a need to increase the hourly rates it receives for the provision of services to the PACE Center. The costs associated with the provision of services by UCI have increased. In addition, staff is recommending contracting with additional providers of primary care services to provide appropriate coverage for the ongoing operation of PACE (see below). It is recommended that the Board establish a maximum hourly rate for PACE physician and non-physician services, and authorize staff to enter into appropriate contracts at rates up to the Board-established maximum. Staff is recommending a maximum rate for physician services of $200.00 per hour, and a maximum rate for non-physician primary care services of $130.00 per hour. The actual rates within the allowable range would be set based on the provider's training, experience, and other resources brought to the provision of the services at the PACE Center (e.g., UCI has requested to provide additional services using Fellows and residents at no cost to CalOptima).

UCI Incentives: Staff requests authorization to add an incentive program for UCI at PACE to focus on increasing patient satisfaction; increasing accuracy of documentation of participant care; and reducing inappropriate inpatient admissions. Please note that the implementation of the incentive plan is subject to regulatory approvals. A detailed grid of the proposed program is attached to this COBAR.

- Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with the medical care provided at the PACE center. Participant medical care and overall

satisfaction with PACE are measured. UCI is eligible to receive an incentive based on a 90% or higher participant satisfaction score.

- Physician documentation of patient care is essential the delivery of quality care and insures appropriate payment from State and federal entities. CalOptima Staff, using audit processes that align with industry standards, will audit physician documentation biannually. UCI will receive additional compensation based on positive results of the audit as reflected on the attached grid.

- As the primary care provider for PACE participants, UCI primary care providers are essential in appropriately assessing a participant's condition and avoiding unnecessary inpatient admissions. Participation in the concurrent review process helps prevent under and over utilization of services. Assisting in the transition of care for a participant from an acute care setting assures the member will continue to receive the care they need and will reduce readmissions. If successful in reducing bed days per thousand per year to the levels identified in the incentive grid attached, UCI will be eligible for a portion of the savings attributed to inpatient costs for PACE. The target bed days per thousand per year are based on CalPACE benchmarks.

Revision to the Scope of Work: Staff requests authority to revise the scope of work to modify responsibilities and qualifications of the physician and NPMP rendering Primary Care services and add responsibilities for UCI to provide clinical Medical Director services. UCI may incorporate care provided by Fellows and residents at the PACE clinic, under the condition that these services are overseen by an onsite contracted UCI physician. The Fellows and residents will be provided at no cost to CalOptima and will enhance the number of providers rendering services at the PACE center.

Updating of Contract Form: In addition to the above changes, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract also be included.

Additional Authority to Contract: Staff requests authority to contract with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE. Additional providers include, but are not limited to, local Primary Care physicians, Locum Tenens and NPMPs. These providers will be paid at the CalOptima fee schedule.

**Fiscal Impact**

The recommended action to revise the rate paid to UCI effective September 1, 2017 through June 30, 2018, modify the compensation methodology for on-call services, and implement an incentive payment program is an unbudgeted item. Based on current utilization, funding for the recommended action will increase medical expenses by $80,000, thereby reducing budgeted income for the PACE program to

$131,373 for Fiscal Year 2017-18. Management will include updated PACE medical expenses in future operating budgets.

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain the contractual relationship with UCI for the provision of Primary Care services to CalOptima PACE and to ensure coverage of Primary Care services for PACE.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. Board Action dated November 3, 2011, Authorize the Chief Executive Office to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE.
2. CalOptima PACE PCP Incentive Program Grid

*/s/ Michael Schrader* *9/1/2017*

**Authorized Signature** **Date**

# CalOptima Board Action Agenda Referral

**Action To Be Taken November 3, 2011**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**
VI. B. Authorize the Chief Executive Officer (CEO) to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE

**Contact**
Peerapong Tantameng, Manager, PACE (714) 246-8400

**Recommended Action**
Authorize the CEO, with the assistance of legal counsel, to amend existing medical provider and administrative support vendor contracts to include PACE, and to enter into new medical provider and administrative support vendor contracts as necessary for operation of PACE within the parameters of the Board-approved operating budget.

**Background**
PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program will be the first PACE program offered to Orange County residents. Also, CalOptima will be the first County Organized Health System to offer a PACE program to its members.

The hub of a PACE program is the PACE Center, a medically-intensive care coordination facility that provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide a full range of necessary services outside of the PACE Center setting to ensure the proper continuum of care, including, but not limited to:

- Transportation to the PACE center and to medical appointments
- Skilled and personal home care
- Inpatient, outpatient, and specialty care
- Nursing home care, both short and long-term
- Home-delivered meals
- Durable medical equipment

**Discussion**
On October 7, 2010, the CalOptima Board of Directors authorized the CEO to submit CalOptima's PACE application to the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). At that time, staff committed to returning to Board to obtain authority to implement operational items for PACE and which are

required by federal and state regulations, including the execution of contracts with the necessary providers and vendors, many of which are subject to state licensure requirements, to adequately serve CalOptima members who enroll in PACE.

CalOptima staff now seeks authority to amend existing agreements and enter into new agreements with providers and vendors, subject to regulatory approval of CalOptima's PACE program, to offer the necessary medical, social, and community-based services required of a PACE program, including but not limited to the following types of medical providers and administrative support vendors:

- Medical Director;
- PACE Center-based practitioners, including the primary care physician and rehabilitation therapists;
- Medical specialists for the PACE provider network;
- Hospitals;
- Ancillary health services, including dental, audiology, optometry, podiatry, speech therapy, and behavioral health;
- Nursing facilities, for both acute and long-term care;
- Laboratory services;
- Durable medical equipment;
- Home care and home health;
- Transportation;
- Meal service; and
- Electronic Health Record system

Fortunately, many of the provider network needs for PACE can be addressed by amending contracts with providers within the designated PACE service area who are already contracted with CalOptima under its other lines of business. While provider and vendor contracts must include certain regulatory terms that are required by DHCS and CMS, many of these terms are similar to those required for CalOptima's current Medi-Cal and OneCare programs. However, because CalOptima will be a new entrant into the PACE program, staff anticipates that, within the bounds of regulatory and budgetary limitations, there may be a need for variations among agreements based upon the type of provider or vendor, PACE regulatory requirements, and unique institutional requirements that providers or vendors may have in finalizing CalOptima agreements. Staff's proposed strategy is to approach providers and vendors with uniform sets of terms and conditions to minimize the number and scope of variances between contracts. Staff will update the Board of Directors on the progress of the contracting efforts as they move forward.

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**Fiscal Impact**

It is anticipated that the amendments and new contracts to be negotiated with medical providers and vendors for administrative services will be consistent with the projected expenses reflected in the operational budget for PACE approved by the Board on June 2, 2011.

**Rationale for Recommendation**

As a new entrant to the PACE market and given the tight timeline for bringing up the PACE program, CalOptima will need to both amend contracts with existing medical providers and administrative support vendors, as well as enter into agreements with new medical providers and administrative support vendors. Through this process, staff plans to put in place the various contractual relationships that are necessary for the proper operation of the CalOptima PACE program.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

*/s/ Richard Chambers* — *10/28/11*

**Authorized Signature** — **Date**

## CalOptima PACE PCP Incentive Program

| Measure | Background | Time Period | Time of Measurement | Metric Detail | Scoring | Amount | Payment |
|---|---|---|---|---|---|---|---|
| Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care | PCP's are important component of the medical team which provides care to the participants at the PACE center. | CY | CY Q4 | Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score* | <90% | $0 PMPM | April |
| | | | | | >/= 90% | $1 PMPM | April |
| Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction | Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE. | CY | CY Q4 | Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score** | < 90% | $0 PMPM | April |
| | | | | | >/= 90% | $1 PMPM | April |
| Coding Accuracy Rate | Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis. | CY | Biannually | The CalOptima Coding Department will audit charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits. | <75% | $0 PMPM | April |
| | | | | | 75-89% | $0.5 PMPM | April |
| | | | | | >/= 90% | $1 PMPM | April |
| CalOptima PACE Actual Inpatient Performance | Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP. | CY for 1st 6 Months of 2018 | Audited CY Performance for the 1st 6 Months of 2018 | PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016. | Incentive Begins at BD / K / Y equivalent of 2,300 | Total potential: $19.30 PMPM or ~ $30,000*** | October, 2018 |
| | | | | | Incentive ends at BD / K / Y equivalent of 2,000 | | |
| | | FY Starting July 1st, 2018 | Audited FY Performance | Will be determined by budget and CalPACE updated averages | TBD | TBD | October, 2019 |
| | | | | | TBD | TBD | |

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.
*** Potential incenitve was estimated based on the projected member months from January, 2018 to June, 2018.

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# CalOptima Board Action Agenda Referral

**Action to Be Taken September 5, 2019**
**Regular Meeting of the CalOptima Board of Directors**

**Consent Calendar**
4. Consider Appointments of Member Advisory Committee Chair and Vice Chair

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

**Recommended Actions**
The Member Advisory Committee (MAC) recommends the appointments of Christine Tolbert as the MAC Chair and Pamela Pimentel as the MAC Vice Chair, each for one-year terms ending June 30, 2020.

**Background**
The CalOptima Board of Directors established the Member Advisory Committee (MAC) by resolution on February 14, 1995 to serve solely in an advisory capacity providing input and recommendations concerning the CalOptima program. The MAC is comprised of fifteen (15) voting members, including two standing members: one representative each from the Orange County Health Care Agency and the Orange County Social Services Agency.

Pursuant to Resolution No. 95-0214, the CalOptima Board of Directors is responsible for the appointment of the Chair annually from among appointed members. The Chair may serve two consecutive one-year terms.

Pursuant to Resolution No. 16-0804, the CalOptima Board of Directors is responsible for the appointment of the Vice Chair annually from among appointed members. The Vice Chair may serve two consecutive one-year terms.

**Discussion**
In the month leading up to the August 8, 2019 meeting, members of the MAC were asked to submit letters of interest for the Chair and Vice Chair positions to the Staff of the Advisory Committees. Prior to the August 8, 2019 MAC meeting, MAC members received information with letters of interest from applicants interested in the Chair and Vice Chair positions. Christine Tolbert submitted a letter of interest for the Chair and the MAC voted to recommend Christine Tolbert. Pamela Pimentel and Sally Molnar submitted letters of interest for the Vice Chair.

Recommend candidates for Chair and Vice Chair are as follows with information from their letters of interest:

***MAC Chair Candidate***
Christine Tolbert*

Ms. Tolbert serves on the MAC as a Persons with Special Needs representative and has represented Members with Special Needs for last three years on the MAC through consistent attendance at MAC

meetings and participation in many subcommittee meetings. Ms. Tolbert's current work for the State Council on Developmental Disabilities has allowed her to advocate for hundreds of people dealing with an expansive number of medical and/or special needs conditions. She has helped transition people from state hospitals into the community, assisting with their transition to managed care and accessing health care services.

***MAC Vice Chair Candidates***
Sally Molnar
Pamela Pimentel*

Sally Molnar serves on the MAC as the Medically Indigent Persons representative and advocates for breast health screenings and treatment programs that provide a safety net for under-insured and uninsured women in Orange County. She currently serves as the Public Policy Chair and advocates for breast cancer services at the state and federal level. She has volunteered with the Orange County Affiliate of the Susan G. Komen Breast Cancer Foundation, Inc. for 27 years in various capacities. Ms. Molnar believes her service on the MAC is important as safety net services continue to shrink.

At the August 8, 2019 MAC meeting, Ms. Molnar requested that her name be removed from consideration for the role of MAC Vice Chair.

Pamela Pimentel serves on the MAC as a Children's representative. For nine years, she served on the Provider Advisory Committee (PAC) representing the allied health, safety net, and nursing community prior to joining MAC. During her tenure on PAC, she served as the PAC Chair for six years. Ms. Pimentel has worked with CalOptima since its beginning in 1993 and participated in many of the town hall meetings held by the Board of Supervisors in 1991 and 1992 that led to the formation of CalOptima. During her 44-year nursing career, she has focused on serving some of the most vulnerable members of the community: pregnant moms and their babies.

**Fiscal Impact**
There is no fiscal impact.

**Rationale for Recommendation**
An open nomination was held at the August 8, 2019 MAC meeting based on the letters of interest received and there were no additional nominations from the floor. The MAC forwards the recommended Chair and Vice Chair to the Board of Directors for consideration.

**Concurrence**
Member Advisory Committee
Gary Crockett, Chief Counsel

*Indicates MAC recommendation

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**Attachments**
None

*/s/ Michael Schrader* *8/28/19*
**Authorized Signature** **Date**

*Indicates MAC recommendation

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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**

5. Consider Ratifying Revisions to CalOptima Financial Policies and Procedures Related to the Whole-Child Model Program

**Contact**

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

**Recommended Action**

Ratify revisions to CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks, effective July 1, 2019.

**Background**

The California Children's Services (CCS) program provides medical care, case management, physical therapy, occupational therapy and financial assistance to children under age twenty-one who meet eligibility criteria based on financial and medical conditions. The Department of Health Care Services (DHCS) is integrating CCS services into Medi-Cal managed care plans for County Organized Health Systems (COHS) plans on a phased-in basis.

At its June 7, 2018 meeting, the CalOptima Board of Directors (Board) authorized the execution of an Amendment to the Primary Agreement between DHCS and CalOptima with respect to implementation of the Whole Child Model (WCM) program.

At its August 2, 2018 meeting, the Board approved actions related to the WCM provider payment methodology. The staff report included information on DHCS capitation rates, projected medical costs, and an overview of the provider payment model for CalOptima direct networks and delegated Health Networks.

At its October 4, 2018 meeting, the Board approved revisions to and the development of new Medi-Cal financial policies and procedures related to the WCM and CalOptima's annual policy review, including CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks

On November 9, 2018, DHCS delayed the implementation date for the transition of the CCS program in Orange County from January 1, 2019 to no sooner than July 1, 2019. Based on the significant CCS-eligible population and the complexity of CalOptima's delegated delivery system, DHCS determined that additional time was necessary to ensure effective preparation and a robust number of CCS-paneled providers.

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**Discussion**
Staff is presenting revisions to the version of CalOptima Policy FF.4000: Whole-Child Model- Financial Reimbursement for Capitated Health Networks presented to and approved by the Board at its October 4, 2018 meeting.

Pursuant to the revised implementation date for the WCM program in Orange County, Staff recommends revisions to CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks. This policy establishes the reimbursement process for CalOptima to distribute WCM payments in a timely and accurate manner to delegated Health Networks. Specifically, the policy describes the methodology used to calculate and adjust WCM payments, defines the measurement period for WCM payments, describes the types of payments for each measurement period, and gives payment distribution timelines. The following points provide a summary of the proposed revisions and clarify the process:

- Revised the risk corridor reconciliation period from a calendar year basis to a fiscal year basis due to the delayed implementation date from January 1, 2019, to July 1, 2019;

- Revised the measurement period for WCM payments from a calendar year basis to a fiscal year basis due to the delayed implementation date from January 1, 2019, to July 1, 2019, and other conforming changes to reflect the new measurement and payment periods;

- Added Section II.D. to include policy that CalOptima-Direct-Administrative is financially responsible for all Covered Services provided during a month where a CCS-eligible Member has retroactive eligibility;

- Under Section II.G., clarified policy that the provisions for Health Network reimbursement methodology does not apply to Kaiser Foundation Health Plan, Inc., (Kaiser);

- Under Section II.H., added policy for Kaiser's reimbursement methodology for enrolled CCS-eligible members;

- Under Section II.F., revised policy to finalize the refreshed report for risk corridor reconciliation after keeping each Measurement Period open for thirty (30) months after the end of each Measurement Period. The August 2, 2018, Board action noted that each annual reconciliation report would contain refreshed reports from the previous two (2) annual settlement periods, and that after two (2) years, the refreshed reports would be considered final;

- Added Section II.I., to include policy allowing CalOptima to adjust the Health Network initial capitation payment rates subject to DHCS funding updates for the Measurement Period. The revision expressly denotes this allowable adjustment to Health Network initial capitation payment rates that was not included in the August 2, 2018, Board action;

- Under Section III.B., Interim Catastrophic Payment, clarified procedures and timelines related to submission of expenses and documentation by Health Networks and notification by CalOptima, and added procedures related to an expedited cash funding payment to Health Networks in

extraordinary cases or significant cash deficiencies to provide additional protection in the event of an extraordinary event or cash flow issues. The procedures include the timeframe in which CalOptima will review, make a final determination and provide notification to the Health Network;

- Under Section III.C., Retrospective Risk Corridor, clarified procedures related to the calculation and determination of a risk corridor recoupment, and added procedures related to an expedited cash funding payment to Health Networks due to significant cash deficiencies to provide additional protection in the event of cash flow issues;

- Under Section III.C.3.a. procedure, interim catastrophic reimbursement payments would be included in the risk corridor reconciliation process, but not included in the baseline calculation for the retrospective risk corridor reconciliation. The August 2, 2018, Board action noted that CalOptima would use the prospective capitation rate as the basis for the risk corridor reconciliation and would account for funding paid through the interim catastrophic reimbursement payment process during the reconciliation process;

- Under Section III.C.3.e., clarified the basis of calculating the administrative and medical management components of CCS reimbursement. The August 2, 2018, Board action, noted CalOptima would keep the administrative load percentage fixed at 6.6%. The procedure revision clarifies that the established percentage will be the DHCS-established administrative rate for the rate period, subject to a final reconciliation after DHCS issues final rates;

- Added Section III.E., to include procedures related to repricing adjustments in extraordinary cases where a claim is paid at rates greater than the CalOptima contracted or non-contracted rates, including a Health Network submission of a written request for additional review, and CalOptima's evaluation, determination and application of any repricing adjustments;

- Added Section III.F., to include procedures for providers to file a complaint pursuant to CalOptima Policy HH.1101 CalOptima Provider Complaint, if necessary; and

- Added Section III.G., to include a payment methodology with Kaiser for enrolled CCS-eligible members. The policy establishes a schedule for Kaiser to submit a monthly report to CalOptima and the procedure and timeline for repricing, reconciliation and payment of covered hospital, physician, ancillary, facility and pharmacy expenses for CCS-eligible members. The policy included procedures for Kaiser to file a complaint pursuant to CalOptima Policy HH.1101 CalOptima Provider Complaint, if necessary. CalOptima shall provide a monthly administrative capitation payment to Kaiser and shall validate and reprice submitted claims based on the following rates:

| Claims Type | Rate |
|---|---|
| Internal Kaiser pharmacy claims | Equivalent of 100% of the CalOptima contracted pharmacy network rate |
| Physician, hospital, ancillary Kaiser system claims | Equivalent of 100% of the CalOptima Medi-Cal Fee Schedule |

| Claims Type | Rate |
|---|---|
| Professional services provided by Kaiser system CCS-paneled providers | 140% of the CalOptima Medi-Cal Fee Schedule |
| Non-HMO Kaiser system pharmacy and other services | CalOptima will reprice the claims at:<br>• Rate paid by Kaiser under its contract with the provider; or<br>• Rate negotiated and paid by Kaiser<br><br>If Kaiser enters into a contract with CalOptima providers that have reciprocity requirements, CalOptima will reprice the claim at the contracted reciprocal rate. |

Since the WCM program began on July 1, 2019, Management recommends the Board ratify revisions to CalOptima FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks effective as of that date.

**Fiscal Impact**

The recommended action to revise CalOptima Policy FF.4000 is a budgeted item under the Medi-Cal-WCM program in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

**Rationale for Recommendation**

The recommended action will ensure CalOptima's policies and procedures are established to comply with state requirements for the WCM program.

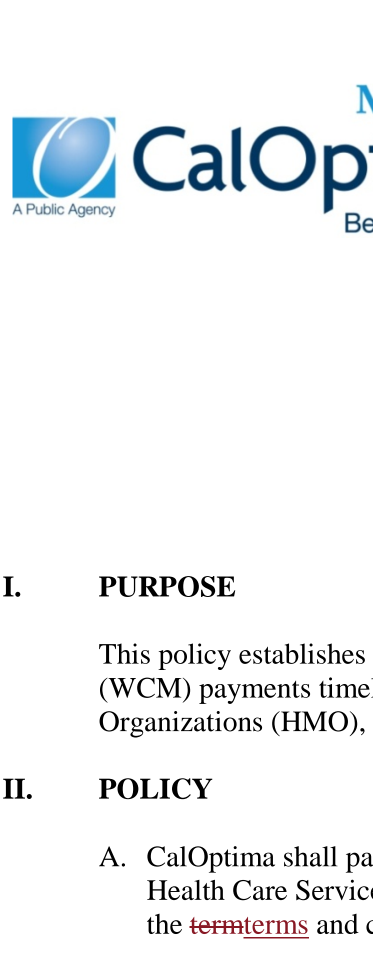
**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks
2. Board Action dated August 2, 2018, Consider Actions Related to CalOptima's Medi-Cal Whole-Child Model Program Provider Payment Methodology
3. Board Action dated October 4, 2018, Consider Revisions and Development of CalOptima Financial Policies and Procedures Related to the Whole-Child Model Program and Annual Policy Review
4. DHCS All Plan Letter 18-023 California Children's Services Whole Child Model Program

*/s/ Michael Schrader* *8/28/19*
**Authorized Signature** **Date**




Policy~~ #~~: FF.4000
Title: **Whole-Child Model – Financial Reimbursement for Capitated Health Networks**
Department: Finance
Section: Accounting

CEO Approval: Michael Schrader _______

Effective Date: 07/01/~~01/19~~2019
~~Last Review Date:~~ ~~Not Applicable~~
~~Last~~ Revised Date: Not Applicable

~~*Board Approved Policy*~~

DRAFT

## I. PURPOSE

This policy establishes the reimbursement process for CalOptima to distribute Whole-Child Model (WCM) payments timely and accurately to Health Networks, including Health Maintenance Organizations (HMO), Physician Hospital Consortiums (PHC), and Shared Risk Groups (SRG).

## II. POLICY

A. CalOptima shall pay the Health Network in accordance with the Health Network's Contract for Health Care Services, the CalOptima Board of Directors (BOD)-approved payment methodology, and the ~~term~~terms and conditions of this Policy.

B. CalOptima's WCM reimbursement methodology for Health Networks is based on the number of California Children's Services (CCS) Program-eligible Members, as ~~reported~~identified by the ~~California Department of Health Care Services (DHCS)~~local CCS program and enrolled in Health Networks during the applicable period.

C. If ~~DHCS~~ the local CCS Program identifies that an individual was not eligible for the CCS Program and retroactively terminates CCS eligibility, CalOptima shall recover payments made to the Health Networks for such individual.

D. CalOptima Direct-Administrative is financially responsible for all Covered Services provided during a month in which a CCS-eligible Member has retroactive eligibility.

E. In accordance with CalOptima Policy FF.1007: Health Network Reinsurance Coverage, CalOptima shall exclude Members from the provision of reinsurance as of the effective date of the Member being CCS-eligible.

~~D.~~F. The ~~measurement period~~Measurement Period for WCM payments is established by ~~calendar~~fiscal year (~~CY).~~ FY), July 1 to June 30. In accordance with Section II.J.3 of this policy, CalOptima shall keep each ~~measurement period~~Measurement Period (FY1) open for ~~three (3) consecutive calendar years (Year 1, Year 2, and Year 3)~~thirty (30) months after the end of each Measurement Period before the ~~payment~~risk corridor reconciliation is considered ~~closed~~finalized (e.g., ~~measurement period CY~~Measurement Period FY 2019-20 (July 1, 2019 – June 30, 2020) will be finalized based on claims paid through December 31, ~~2021).~~2022).


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

~~E.~~G. CalOptima reimburses Health Networks, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), for services rendered to enrolled CCS-eligible Members based on a methodology that includes the following components described in this Policy:

1. Initial Capitation Payments;

2. Interim catastrophic payment; and

3. Retrospective risk corridor settlements.

H. CalOptima shall reimburse Kaiser for services rendered to enrolled CCS-eligible Members based on a methodology described in Section III.G. of this Policy.

I. CalOptima may adjust Health Network initial Capitation Payment rates subject to Department of Health Care Services (DHCS) funding updates for the Measurement Period.

~~F.~~J. The WCM payment timelines are:

1. Initial Capitation Payment: CalOptima shall pay monthly on or before the fifteenth (15th) calendar day of the month.

2. Interim catastrophic ~~reimbursement~~payment: CalOptima shall pay quarterly based on the refreshed data for each ~~measurement period~~Measurement Period as follows:

| CCS Eligible and Claims Incurred for Dates of Service | Claims Payment Period | ~~Risk Corridor Settlement~~Interim Catastrophic Calculation (Payment/ Recoupment) Date |
|---|---|---|
| ~~January~~July 1 – ~~March 31, Year 1~~September 30, FY1 | ~~Year 1~~FY1 paid through ~~March 31~~September 30, FY1 | No later than ~~June 15, Year 1~~November 30, FY1 |
| ~~January~~July 1 – ~~June 30, Year 1~~December 31, FY1 | ~~Year 1~~FY1 paid through ~~June 30~~December 31, FY1 | No later than ~~September 15, Year 1~~February 28, FY1 |
| ~~January~~July 1 – ~~September 30, Year 1~~March 31, FY1 | ~~Year 1~~FY1 paid through ~~September 30~~March 31, FY1 | No later than ~~December 15, Year 1~~May 31, FY1 |
| ~~January~~July 1 – ~~December 31, Year 1~~June 30, FY1 | ~~Year 1~~FY1 paid through ~~December 31~~June 30, FY1 | No later than ~~March 15, Year 2~~August 31, FY2 |
| ~~January~~July 1 – ~~December 31, Year 1~~June 30, FY1 | ~~Year 1~~FY1 paid through ~~March 31, Year 2~~September 30, FY2 | No later than ~~June 15, Year 2~~November 30, FY2 |

3. Retrospective risk corridor settlement: CalOptima shall pay annually based on the refreshed data for each ~~measurement period~~Measurement Period as follows:

| Measurement Period (CCS Eligible and Claims Incurred for Dates of Service for FY1) | Claims Payment Period | Risk Corridor Settlement (Payment/ Recoupment) Date |
|---|---|---|
| ~~January~~July 1 – ~~December 31, Year 1~~June 30, FY1 | ~~Year 1~~Measurement Period plus 6 months: FY1 paid through ~~June 30, Year 2~~December 31, FY2 | No later than ~~November~~May 15, ~~Year 2~~FY2 |

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| ~~January~~July 1 – ~~December 31, Year 1~~June 30, FY1 | ~~Year 1~~Measurement Period plus 18 months: FY1 paid through ~~June 30, Year 3~~December 31, FY3 | No later than ~~November~~May 15, ~~Year 3~~FY3 |
| --- | --- | --- |
| ~~January~~July 1 – ~~December 31, Year 1~~June 30, FY1 | ~~Year 1~~Measurement Period plus 30 months (final): FY1 paid through ~~June 30, Year 4~~December 31, FY4 | No later than ~~November~~May 15, ~~Year 4~~FY4 |

## III. PROCEDURE

A. Initial Capitation Payment

1. CalOptima shall provide monthly capitation payments for CCS-eligible Members enrolled ~~to~~in the Health Networks at Capitation Rates per Member per month (PMPM) developed by CalOptima, approved by the BOD and set forth in the Health Network's Contract for Health Care Services.

2. CalOptima shall process the initial Capitation Payment in accordance with CalOptima Policy FF.1001: Capitation Payments. CalOptima shall issue one (1) payment that includes the initial Capitation Payment for CCS-eligible Members combined with the Capitation Payment for non-CCS eligible Members.

B. Interim Catastrophic ~~Reimbursement~~Payment

1. Health Networks shall submit paid claims ~~paid~~through the existing monthly External Decision Data submission for covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members monthly, by the fifteenth (15th) calendar day after the month ends for all ~~open measurement periods.~~Open Measurement Periods. Health Networks shall submit claims using ~~CalOptima~~CalOptima's proprietary format and file naming convention.

   a. An HMO, with the exception of Kaiser, shall submit claims for covered hospital and covered physician expenses;

   b. The Primary Physician Group of a PHC shall submit claims for covered physician expenses;

   c. The Primary Hospital of a PHC shall submit claims for covered hospital expenses; and

   d. An SRG shall submit claims for covered physician expenses.

2. CalOptima shall validate and reprice the submitted claims based on the CalOptima contracted and non-contracted rates following the lesser of the amount paid for covered physician and hospital expenses. Repricing will be made at fifty percent (50%) of the amount paid if Medi-Cal has no value for the five (5)-digit numerical Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, or other code as assigned by DHCS. ~~The qualified~~These allowable claims, as determined by CalOptima, shall represent the ~~qualified~~repriced WCM medical expenses used in the reconciliation process for the interim catastrophic reimbursement. ~~Outlier claims~~Claims paid by the Health Network at a higher rate than would be payable by CalOptima, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

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3. Upon request, an eligible Health Network shall provide, within ~~ten (10~~five (5) business days, detailed support for any individual claim for which billed charges are greater than or equal to ten thousand dollars ($10,000), including copies of the claim form, cancelled check, explanation of benefits (EOB), Remittance Advice Detail (RAD), and other information as requested by CalOptima. All non-contracted emergency hospital inpatient claims require submission of the authorization distinguishing days considered emergency and post-stabilization.

4. CalOptima shall notify an eligible Health Network of file acceptance or rejection ~~within ten (10) business days after receipt~~no later than three (3) business days after receipt. CalOptima may reject a file for missing information or incorrect data. If CalOptima rejects a file, an eligible Health Network shall resubmit a corrected file no later than September 30, FY2 of the claims payment period pursuant to Section II.J.2 of this Policy. Any timely resubmission after the fifteenth (15th) of the month will be included in the subsequent month's process. A paid claims file initially submitted or a corrected file resubmitted by an eligible Health Network after the September 30, FY2 deadline will be processed in accordance with the requirements of the annual retrospective risk corridor reconciliation as set forth in Sections II.J.3 and III.C of this Policy.

   ~~a.~~ For a complete claims paid file accepted by CalOptima ~~may reject a file for any missing information or incorrect data.~~

5. ~~If,~~ CalOptima ~~rejects a file, the~~shall notify an eligible Health Network ~~shall resubmit a corrected file within five (5) business days from receipt of notification from CalOptima.~~of the results as follows:

   a. If CalOptima receives the file by the fifteenth (15th) of the month, notice of the results will be provided no later than thirty (30) business days after the fifteenth (15th) of that month.

   b. If CalOptima receives the file after the fifteenth (15th) of the month, notice of the results will be provided no later than thirty (30) business days after the fifteenth (15th) of the subsequent month.

6. An eligible Health Network may appeal claim denials and payments within sixty (60) business days after the date of CalOptima's ~~RAD.~~quarterly Interim Catastrophic payment remittance advice.

   a. The eligible Health Network shall submit a request for appeal, in writing, to CalOptima at:

      WCMReimb@caloptima.org

      Or by U.S. mail to:

      Attention: Coding Initiatives Department—~~Reinsurance~~WCM Claims
      CalOptima
      505 City Parkway West
      Orange, CA 92868

   b. An appeal claims submission file shall only include specific claims to be reconsidered.

   c. The eligible Health Network shall provide detailed claims support for each claim, including copies of the claim form, cancelled check, EOB, RAD, or any other information, as requested by CalOptima.

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d. CalOptima shall notify the eligible Health Network of file acceptance or rejection within ~~ten (10~~three (3) business days after receipt of the appeal file.

   i. CalOptima may reject a file for any missing information or incorrect data.

   ii. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days after receipt of notification from CalOptima.

e. CalOptima shall process an appeal and provide an eligible Health Network with the detailed ~~reports~~report and payment, if applicable, on the following quarterly reimbursement period or within forty-five (45) business days after receipt of the appeal~~.~~, whichever is later.

7. For each CCS-~~-~~eligible Member in a given ~~measurement period~~Measurement Period, CalOptima shall reimburse at one hundred percent (100%) of the repriced amount ~~of~~for the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members in excess of the thresholds which are:

   a. $17,000 for covered physician expenses; and

   b. $150,000 for covered hospital expenses.

8. CalOptima shall reconcile covered physician and covered hospital expenses separately.

9. CalOptima shall issue interim catastrophic payments to Health Networks in accordance with the timelines in Section II.~~F~~J.2 of this Policy.

10. In the event of an extraordinary case(s) or significant cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

    a. Within forty-five (45) business days after receipt of the Health Network's request, CalOptima Claims Department will review the request and documentation and forward the recommendation to approve or deny the request to CalOptima Chief Executive Officer (CEO) and Chief Financial Officer (CFO).

    b. The CEO and CFO will make a final determination. CalOptima Finance Department will provide written notification of the final determination to the Health Network no later than sixty (60) business days after receipt of the Health Network's request. If and to the extent approved by CalOptima, the expedited cash funding will be included and reconciled in the next quarterly interim catastrophic payment or annual risk corridor calculation.

C. Retrospective Risk Corridor

1. After the ~~June~~December claims submission, CalOptima shall perform an annual retrospective risk corridor reconciliation for all ~~open measurement periods~~Open Measurement Periods.

2. CalOptima shall validate and reprice the submitted claims ~~documents~~, as described in Sections III.B.1 and III.B.2. of this Policy, based on the lesser of the CalOptima contracted and non-contracted rates or the amount actually paid for covered physician and hospital expenses. Repricing will be made at fifty percent (50%) of the amount paid if Medi-Cal has no value for the five-digit numerical CPT code, HCPCS code, or other code as assigned by the DHCS. ~~The qualified~~These allowable claims, as determined by CalOptima, shall represent the covered

hospital and covered physician expenses rendered to enrolled CCS-eligible Members used in the retrospective risk corridor reconciliation. Similar to the interim catastrophic reimbursement, ~~outlier claims~~claims paid by the Health Network at a higher rate than would be payable by CalOptima, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

3. CalOptima shall perform the retrospective risk corridor reconciliation for physician Capitation and hospital Capitation separately.

   a. The baseline for the retrospective risk corridor reconciliation is an amount equal to the total Capitation Rate PMPM less the administrative and medical management loads PMPM developed by CalOptima, approved by the BOD, and set forth in the Health Network's Contract for Health Care Services, multiplied by the number of CCS-eligible Members enrolled in the Health Networks during the applicable ~~measurement period.~~Measurement Period.

   b. The net difference between the baseline and the qualified WCM medical expenses from Section III.C.2 of this Policy shall be applied to the risk corridor ranges approved by the BOD to determine an amount to be added or subtracted in the retrospective risk corridor reconciliation and referred to as risk corridor result in this Policy.

| Threshold | CalOptima's Risk/Surplus Share |
|---|---|
| > 115% | 95% |
| 115% | 90% |
| 105% | 75% |
| 102% | 50% |
| 100% | 0% |
| 98% | 50% |
| 95% | 75% |
| 85% | 90% |
| < 85% | 100% |

   c. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A. and III.B. of this Policy respectively for the applicable ~~measurement period~~Measurement Period results in a positive amount, the retrospective risk corridor reconciliation computes the risk corridor payment.

   d. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A and III.B of this Policy respectively for the applicable ~~measurement period~~Measurement Period results in a negative amount, the retrospective risk corridor reconciliation computes the risk corridor recoupment~~.~~, which will be deducted from future initial Capitation Payments pursuant to Section III.C. of this Policy.

   e. Administrative and medical management components of CCS reimbursement will be ~~adjusted~~ based on total reimbursement at the ~~actual payout amount at previously~~ established percentage, inclusive of all reimbursement attributed to the Measurement Period regardless of when paid, including the Initial Capitation Payment, Interim Catastrophic Reimbursement, and Retrospective Risk Corridor settlements. The established percentage shall be the

administrative rate established by DHCS for the WCM program for the rate period, subject to a final reconciliation process once DHCS issues final rates for the rate period.

4. No later than ~~October~~March 31, CalOptima shall provide the retrospective risk corridor reconciliation to the Health Networks. If, upon review of the retrospective risk corridor reconciliation, the Health Networks object to the calculations or medical expenses determination, the Health Networks may follow the dispute process outlined in Section III.B.~~5.~~ 6. of this Policy within thirty (30) calendar days from the issuance of the retrospective risk corridor reconciliation.

5. If CalOptima does not receive any written objection from the Health Networks, CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the expiration of the review period or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the expiration of the review period.

6. If CalOptima receives written objection from the Health Networks within the objection period, CalOptima shall review and provide responses to the Health Networks within forty-five (45) calendar days after the date of receipt of the written objection.

7. CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the date of issuance of the final retrospective risk corridor reconciliation or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the issuance of the final retrospective risk corridor reconciliation~~.~~.

8. ~~D.~~ In the event of significant interim cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

   a. Within the time limit specified in Section III.B.10.a. of this Policy, CalOptima Claims Department will -review the request and documentation and forward the recommendation to approve or deny the request to the CEO and CFO.

   b. The CEO and CFO will make a final determination. CalOptima will notify the Health Network of the final determination in accordance with Section III.B.10.b. of this Policy. If and to the extent approved by CalOptima, the expedited cash funding will be included and reconciled in the next annual risk corridor calculation.

D. Medical expenses used in the reconciliation process for interim catastrophic reimbursement and retrospective risk corridor settlement shall be consistent with the financial risk in accordance with the Division of Financial Responsibility (DOFR) of the Health Network's Contract for Health Care Services.

~~IV. ATTACHMENTS~~

E. In the event of an extraordinary case(s), where a claim is paid at rates greater than the CalOptima contracted or non-contracted rates, a Health Network may submit a formal written request for additional review. CalOptima will conduct further evaluation of such cases and determine whether any repricing adjustments are warranted and appropriate. Any approved repricing adjustments will be included in the next Interim Catastrophic Payment or annual Retrospective Risk Corridor reconciliation, whichever occurs first.

F. In the event that a Health Network is dissatisfied with the results of the Interim Catastrophic Payment or annual Retrospective Risk Corridor reconciliation after utilizing the dispute process set forth in this

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Policy, then the Health Network shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Policy HH.1101 CalOptima Provider Complaint.

G. Kaiser Reimbursement Process

1. CalOptima shall provide a monthly administrative capitation payment to Kaiser for enrolled CCS-eligible Members following the regular Medi-Cal capitation process and timeline.

2. Kaiser shall submit a monthly report for covered hospital, physician, ancillary, facility and pharmacy expenses for services rendered to enrolled CCS-eligible Members in a format as agreed by CalOptima and Kaiser. Kaiser shall submit a report using CalOptima's proprietary format and file naming convention, or the equivalent, as agreed by CalOptima and Kaiser.

    a. Reimbursement for Kaiser Hepatitis C drug therapy and Behavioral Health Therapy (BHT) claims for services provided to CCS-eligible Members shall be at the same supplemental rates at which such services are reimbursed for all other Kaiser Members, under a separate process. Therefore, all Hepatitis C drug therapy and BHT claims will be excluded from the monthly reconciliation described in Section III.F.4.

3. CalOptima shall validate and reprice the submitted claims based on:

    a. Internal Kaiser pharmacy claims shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima contracted Pharmacy Network rate;

    b. Physician, Hospital and Ancillary Kaiser system claims (services provided by those providers operating through the Kaiser System as defined in Kaiser's Contract for Health Care Services with CalOptima), shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule. CalOptima updates the CalOptima Medi-Cal Fee Schedule in accordance with CalOptima Policy FF.1002 CalOptima Medi-Cal Fee Schedule. Reimbursement will be based on the CalOptima Medi-Cal Fee Schedule in effect on the date of service;

    c. Professional services provided by Kaiser system CCS-paneled providers shall be reimbursed at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule; and

    d. For non-Kaiser system pharmacy and other services, CalOptima shall reprice the claims at the rate paid by Kaiser under its contract with the provider, or the rate negotiated and paid by Kaiser. Kaiser may elect to enter into a contract with CalOptima providers that have reciprocity requirements, in which case, CalOptima will reprice the claim at the contracted reciprocal rate.

4. Repricing Results and Reconciliation

    a. CalOptima shall notify Kaiser of the results within thirty (30) business days after the date of CalOptima's receipt of the complete claims paid file.

    b. Kaiser shall provide a rebuttal to, or acceptance of, the results within thirty (30) business days after the date of receipt of the results.

    c. CalOptima, with the cooperation of Kaiser, shall perform a reconciliation of paid covered service expenses, if necessary.

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d. CalOptima shall issue payment to Kaiser within fifteen (15) business days after receipt of the repricing acceptance or the completion of the reconciliation.

e. In the event that Kaiser is still dissatisfied with the repricing after rebuttal, reconciliation, and payment, then Kaiser shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Policy HH.1101 CalOptima Provider Complaint.

## IV. ATTACHMENT(S)

Not Applicable

## V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy FF.1001: Capitation Payments
D. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
E. CalOptima Policy FF.1007: Health Network Reinsurance Coverage
F. CalOptima Policy HH.1101: CalOptima Provider Complaint

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

~~A.~~ None to Date

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

| Date | Meeting |
|---|---|
| 08/02/2018 | Regular Meeting of the CalOptima Board of Directors |
| 10/04/2018 | Regular Meeting of the CalOptima Board of Directors |

~~A. 10/04/18: Regular Meeting of the CalOptima Board of Directors~~

## VIII. ~~REVIEW/~~REVISION HISTORY

| ~~Version~~ Action | Date | Policy ~~Number~~ | Policy Title | ~~Line~~Program(s) ~~of Business~~ |
|---|---|---|---|---|
| Effective | ~~01~~07/01/2019 | FF.4000 | Whole-Child Model – Financial Reimbursement for Capitated Health Networks | Medi-Cal |

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1 **IX. GLOSSARY**
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| Term | Definition |
|---|---|
| Aid Code | The two (2) character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services. |
| California Children's Services (CCS) Program | The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9. |
| CalOptima Direct-Administrative | The managed Fee-For-Service health care program operated by CalOptima that provides services to Members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct |
| CalOptima Medi-Cal Fee Schedule | Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible. |
| Capitation Rate | The per capita rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age, and gender. |
| Capitation Payment | The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender. |
| Contract for Health Care Services | The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Cared Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract. |
| 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. |
| Division of Financial Responsibility (DOFR) | A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange |
| Health Maintenance Organization (HMO) | A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code. |
| Health Network | A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members enrolled to that Health Network. |

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| Term | Definition |
|---|---|
| Member | A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program. |
| Measurement Period | ~~Calendar~~Fiscal year ~~January~~July 1 to ~~December 31~~June 30. |
| Open Measurement Period | The measurement year will remain open until the third annual report is issued to health network |
| Physician Hospital Consortium (PHC) | A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services. |
| Primary Hospital | A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC). |
| Primary Physician Group | A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC). |
| Shared Risk Group | A Health Network who accepts delegated clinical and financial responsibility for professional services for ~~assigned~~enrolled Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services. |

Policy: FF.4000
Title: **Whole-Child Model – Financial Reimbursement for Capitated Health Networks**
Department: Finance
Section: Accounting

CEO Approval: Michael Schrader _______

Effective Date: 07/01/2019
Revised Date: Not Applicable

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## I. PURPOSE

This policy establishes the reimbursement process for CalOptima to distribute Whole-Child Model (WCM) payments timely and accurately to Health Networks, including Health Maintenance Organizations (HMO), Physician Hospital Consortiums (PHC), and Shared Risk Groups (SRG).

## II. POLICY

A. CalOptima shall pay the Health Network in accordance with the Health Network's Contract for Health Care Services, the CalOptima Board of Directors (BOD)-approved payment methodology, and the terms and conditions of this Policy.

B. CalOptima's WCM reimbursement methodology for Health Networks is based on the number of California Children's Services (CCS) Program-eligible Members, as identified by the local CCS program and enrolled in Health Networks during the applicable period.

C. If the local CCS Program identifies that an individual was not eligible for the CCS Program and retroactively terminates CCS eligibility, CalOptima shall recover payments made to the Health Networks for such individual.

D. CalOptima Direct-Administrative is financially responsible for all Covered Services provided during a month in which a CCS-eligible Member has retroactive eligibility.

E. In accordance with CalOptima Policy FF.1007: Health Network Reinsurance Coverage, CalOptima shall exclude Members from the provision of reinsurance as of the effective date of the Member being CCS-eligible.

F. The Measurement Period for WCM payments is established by fiscal year (FY), July 1 to June 30. In accordance with Section II.J.3 of this policy, CalOptima shall keep each Measurement Period (FY1) open for thirty (30) months after the end of each Measurement Period before the risk corridor reconciliation is considered finalized (e.g., Measurement Period FY 2019-20 (July 1, 2019 – June 30, 2020) will be finalized based on claims paid through December 31, 2022).

G. CalOptima reimburses Health Networks, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), for services rendered to enrolled CCS-eligible Members based on a methodology that includes the following components described in this Policy:

1. Initial Capitation Payments;



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

1
2 2. Interim catastrophic payment; and
3
4 3. Retrospective risk corridor settlements.
5
6 H. CalOptima shall reimburse Kaiser for services rendered to enrolled CCS-eligible Members based on a
7 methodology described in Section III.G. of this Policy.
8
9 I. CalOptima may adjust Health Network initial Capitation Payment rates subject to Department of
10 Health Care Services (DHCS) funding updates for the Measurement Period.
11
12 J. The WCM payment timelines are:
13
14 1. Initial Capitation Payment: CalOptima shall pay monthly on or before the fifteenth ($15^{th}$)
15 calendar day of the month.
16
17 2. Interim catastrophic payment: CalOptima shall pay quarterly based on the refreshed data for each
18 Measurement Period as follows:
19

| CCS Eligible and Claims Incurred for Dates of Service | Claims Payment Period | Interim Catastrophic Calculation (Payment/ Recoupment) Date |
|---|---|---|
| July 1 – September 30, FY1 | FY1 paid through September 30, FY1 | No later than November 30, FY1 |
| July 1 – December 31, FY1 | FY1 paid through December 31, FY1 | No later than February 28, FY1 |
| July 1 – March 31, FY1 | FY1 paid through March 31, FY1 | No later than May 31, FY1 |
| July 1 – June 30, FY1 | FY1 paid through June 30, FY1 | No later than August 31, FY2 |
| July 1 – June 30, FY1 | FY1 paid through September 30, FY2 | No later than November 30, FY2 |

20
21 3. Retrospective risk corridor settlement: CalOptima shall pay annually based on the refreshed data
22 for each Measurement Period as follows:
23

| Measurement Period (CCS Eligible and Claims Incurred for Dates of Service for FY1) | Claims Payment Period | Risk Corridor Settlement (Payment/ Recoupment) Date |
|---|---|---|
| July 1 – June 30, FY1 | Measurement Period plus 6 months: FY1 paid through December 31, FY2 | No later than May 15, FY2 |
| July 1 – June 30, FY1 | Measurement Period plus 18 months: FY1 paid through December 31, FY3 | No later than May 15, FY3 |
| July 1 – June 30, FY1 | Measurement Period plus 30 months (final): FY1 paid through December 31, FY4 | No later than May 15, FY4 |

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25
26 **III. PROCEDURE**



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A. Initial Capitation Payment

1. CalOptima shall provide monthly capitation payments for CCS-eligible Members enrolled in the Health Networks at Capitation Rates per Member per month (PMPM) developed by CalOptima, approved by the BOD and set forth in the Health Network's Contract for Health Care Services.

2. CalOptima shall process the initial Capitation Payment in accordance with CalOptima Policy FF.1001: Capitation Payments. CalOptima shall issue one (1) payment that includes the initial Capitation Payment for CCS-eligible Members combined with the Capitation Payment for non-CCS eligible Members.

B. Interim Catastrophic Payment

1. Health Networks shall submit paid claims through the existing monthly External Decision Data submission for covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members monthly, by the fifteenth (15th) calendar day after the month ends for all Open Measurement Periods. Health Networks shall submit claims using CalOptima's proprietary format and file naming convention.

   a. An HMO, with the exception of Kaiser, shall submit claims for covered hospital and covered physician expenses;

   b. The Primary Physician Group of a PHC shall submit claims for covered physician expenses;

   c. The Primary Hospital of a PHC shall submit claims for covered hospital expenses; and

   d. An SRG shall submit claims for covered physician expenses.

2. CalOptima shall validate and reprice the submitted claims based on the CalOptima contracted and non-contracted rates following the lesser of the amount paid for covered physician and hospital expenses. Repricing will be made at fifty percent (50%) of the amount paid if Medi-Cal has no value for the five (5)-digit numerical Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, or other code as assigned by DHCS. These allowable claims, as determined by CalOptima, shall represent the repriced WCM medical expenses used in the reconciliation process for the interim catastrophic reimbursement. Claims paid by the Health Network at a higher rate than would be payable by CalOptima, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

3. Upon request, an eligible Health Network shall provide, within five (5) business days, detailed support for any individual claim for which billed charges are greater than or equal to ten thousand dollars ($10,000), including copies of the claim form, cancelled check, explanation of benefits (EOB), Remittance Advice Detail (RAD), and other information as requested by CalOptima. All non-contracted emergency hospital inpatient claims require submission of the authorization distinguishing days considered emergency and post-stabilization.

4. CalOptima shall notify an eligible Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for missing information or incorrect data. If CalOptima rejects a file, an eligible Health Network shall resubmit a corrected file no later than September 30, FY2 of the claims payment period pursuant to Section II.J.2 of this Policy. Any timely resubmission after the fifteenth ($15^{th}$) of the month will be included in the

1 subsequent month's process. A paid claims file initially submitted or a corrected file resubmitted
2 by an eligible Health Network after the September 30, FY2 deadline will be processed in
3 accordance with the requirements of the annual retrospective risk corridor reconciliation as set
4 forth in Sections II.J.3 and III.C of this Policy.
5
6 5. For a complete claims paid file accepted by CalOptima, CalOptima shall notify an eligible Health
7 Network of the results as follows:
8
9 a. If CalOptima receives the file by the fifteenth (15th) of the month, notice of the results will be
10 provided no later than thirty (30) business days after the fifteenth (15th) of that month.
11
12 b. If CalOptima receives the file after the fifteenth (15th) of the month, notice of the results will
13 be provided no later than thirty (30) business days after the fifteenth (15th) of the subsequent
14 month.
15
16 6. An eligible Health Network may appeal claim denials and payments within sixty (60) business
17 days after the date of CalOptima's quarterly Interim Catastrophic payment remittance advice.
18
19 a. The eligible Health Network shall submit a request for appeal, in writing, to CalOptima at:
20
21 WCMReimb@caloptima.org
22
23 Or by U.S. mail to:
24
25 Attention: Coding Initiatives Department—WCM Claims
26 CalOptima
27 505 City Parkway West
28 Orange, CA 92868
29
30 b. An appeal claims submission file shall only include specific claims to be reconsidered.
31
32 c. The eligible Health Network shall provide detailed claims support for each claim, including
33 copies of the claim form, cancelled check, EOB, RAD, or any other information, as requested
34 by CalOptima.
35
36 d. CalOptima shall notify the eligible Health Network of file acceptance or rejection within
37 three (3) business days after receipt of the appeal file.
38
39 i. CalOptima may reject a file for any missing information or incorrect data.
40
41 ii. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file
42 within five (5) business days after receipt of notification from CalOptima.
43
44 e. CalOptima shall process an appeal and provide an eligible Health Network with the detailed
45 report and payment, if applicable, on the following quarterly reimbursement period or within
46 forty-five (45) business days after receipt of the appeal, whichever is later.
47
48 7. For each CCS-eligible Member in a given Measurement Period, CalOptima shall reimburse at one
49 hundred percent (100%) of the repriced amount for the covered hospital and covered physician
50 expenses rendered to enrolled CCS-eligible Members in excess of the thresholds which are:
51
52 a. $17,000 for covered physician expenses; and
53

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b. $150,000 for covered hospital expenses.

8. CalOptima shall reconcile covered physician and covered hospital expenses separately.

9. CalOptima shall issue interim catastrophic payments to Health Networks in accordance with the timelines in Section II.J.2 of this Policy.

10. In the event of an extraordinary case(s) or significant cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

    a. Within forty-five (45) business days after receipt of the Health Network's request, CalOptima Claims Department will review the request and documentation and forward the recommendation to approve or deny the request to CalOptima Chief Executive Officer (CEO) and Chief Financial Officer (CFO).

    b. The CEO and CFO will make a final determination. CalOptima Finance Department will provide written notification of the final determination to the Health Network no later than sixty (60) business days after receipt of the Health Network's request. If and to the extent approved by CalOptima, the expedited cash funding will be included and reconciled in the next quarterly interim catastrophic payment or annual risk corridor calculation.

C. Retrospective Risk Corridor

1. After the December claims submission, CalOptima shall perform an annual retrospective risk corridor reconciliation for all Open Measurement Periods.

2. CalOptima shall validate and reprice the submitted claims, as described in Sections III.B.1 and III.B.2. of this Policy, based on the lesser of the CalOptima contracted and non-contracted rates or the amount actually paid for covered physician and hospital expenses. Repricing will be made at fifty percent (50%) of the amount paid if Medi-Cal has no value for the five-digit numerical CPT code, HCPCS code, or other code as assigned by the DHCS. These allowable claims, as determined by CalOptima, shall represent the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members used in the retrospective risk corridor reconciliation. Similar to the interim catastrophic reimbursement, claims paid by the Health Network at a higher rate than would be payable by CalOptima, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

3. CalOptima shall perform the retrospective risk corridor reconciliation for physician Capitation and hospital Capitation separately.

    a. The baseline for the retrospective risk corridor reconciliation is an amount equal to the total Capitation Rate PMPM less the administrative and medical management loads PMPM developed by CalOptima, approved by the BOD, and set forth in the Health Network's Contract for Health Care Services, multiplied by the number of CCS-eligible Members enrolled in the Health Networks during the applicable Measurement Period.

    b. The net difference between the baseline and the qualified WCM medical expenses from Section III.C.2 of this Policy shall be applied to the risk corridor ranges approved by the BOD to determine an amount to be added or subtracted in the retrospective risk corridor reconciliation and referred to as risk corridor result in this Policy.

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| Threshold | CalOptima's Risk/Surplus Share |
|---|---|
| > 115% | 95% |
| 115% | 90% |
| 105% | 75% |
| 102% | 50% |
| 100% | 0% |
| 98% | 50% |
| 95% | 75% |
| 85% | 90% |
| < 85% | 100% |

c. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A. and III.B. of this Policy respectively for the applicable Measurement Period results in a positive amount, the retrospective risk corridor reconciliation computes the risk corridor payment.

d. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A and III.B of this Policy respectively for the applicable Measurement Period results in a negative amount, the retrospective risk corridor reconciliation computes the risk corridor recoupment, which will be deducted from future initial Capitation Payments pursuant to Section III.C. of this Policy.

e. Administrative and medical management components of CCS reimbursement will be based on total reimbursement at the established percentage, inclusive of all reimbursement attributed to the Measurement Period regardless of when paid, including the Initial Capitation Payment, Interim Catastrophic Reimbursement, and Retrospective Risk Corridor settlements. The established percentage shall be the administrative rate established by DHCS for the WCM program for the rate period, subject to a final reconciliation process once DHCS issues final rates for the rate period.

4. No later than March 31, CalOptima shall provide the retrospective risk corridor reconciliation to the Health Networks. If, upon review of the retrospective risk corridor reconciliation, the Health Networks object to the calculations or medical expenses determination, the Health Networks may follow the dispute process outlined in Section III.B.6. of this Policy within thirty (30) calendar days from the issuance of the retrospective risk corridor reconciliation.

5. If CalOptima does not receive any written objection from the Health Networks, CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the expiration of the review period or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the expiration of the review period.

6. If CalOptima receives written objection from the Health Networks within the objection period, CalOptima shall review and provide responses to the Health Networks within forty-five (45) calendar days after the date of receipt of the written objection.

7. CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the date of issuance of the final retrospective risk corridor reconciliation or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the issuance of the final retrospective risk corridor reconciliation.

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8. In the event of significant interim cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

    a. Within the time limit specified in Section III.B.10.a. of this Policy, CalOptima Claims Department will review the request and documentation and forward the recommendation to approve or deny the request to the CEO and CFO.

    b. The CEO and CFO will make a final determination. CalOptima will notify the Health Network of the final determination in accordance with Section III.B.10.b. of this Policy. If and to the extent approved by CalOptima, the expedited cash funding will be included and reconciled in the next annual risk corridor calculation.

D. Medical expenses used in the reconciliation process for interim catastrophic reimbursement and retrospective risk corridor settlement shall be consistent with the financial risk in accordance with the Division of Financial Responsibility (DOFR) of the Health Network's Contract for Health Care Services.

E. In the event of an extraordinary case(s), where a claim is paid at rates greater than the CalOptima contracted or non-contracted rates, a Health Network may submit a formal written request for additional review. CalOptima will conduct further evaluation of such cases and determine whether any repricing adjustments are warranted and appropriate. Any approved repricing adjustments will be included in the next Interim Catastrophic Payment or annual Retrospective Risk Corridor reconciliation, whichever occurs first.

F. In the event that a Health Network is dissatisfied with the results of the Interim Catastrophic Payment or annual Retrospective Risk Corridor reconciliation after utilizing the dispute process set forth in this Policy, then the Health Network shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Policy HH.1101 CalOptima Provider Complaint.

G. Kaiser Reimbursement Process

1. CalOptima shall provide a monthly administrative capitation payment to Kaiser for enrolled CCS-eligible Members following the regular Medi-Cal capitation process and timeline.

2. Kaiser shall submit a monthly report for covered hospital, physician, ancillary, facility and pharmacy expenses for services rendered to enrolled CCS-eligible Members in a format as agreed by CalOptima and Kaiser. Kaiser shall submit a report using CalOptima's proprietary format and file naming convention, or the equivalent, as agreed by CalOptima and Kaiser.

    a. Reimbursement for Kaiser Hepatitis C drug therapy and Behavioral Health Therapy (BHT) claims for services provided to CCS-eligible Members shall be at the same supplemental rates at which such services are reimbursed for all other Kaiser Members, under a separate process. Therefore, all Hepatitis C drug therapy and BHT claims will be excluded from the monthly reconciliation described in Section III.F.4.

3. CalOptima shall validate and reprice the submitted claims based on:

    a. Internal Kaiser pharmacy claims shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima contracted Pharmacy Network rate;

    b. Physician, Hospital and Ancillary Kaiser system claims (services provided by those providers operating through the Kaiser System as defined in Kaiser's Contract for Health Care Services

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with CalOptima), shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule. CalOptima updates the CalOptima Medi-Cal Fee Schedule in accordance with CalOptima Policy FF.1002 CalOptima Medi-Cal Fee Schedule. Reimbursement will be based on the CalOptima Medi-Cal Fee Schedule in effect on the date of service;

c. Professional services provided by Kaiser system CCS-paneled providers shall be reimbursed at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule; and

d. For non-Kaiser system pharmacy and other services, CalOptima shall reprice the claims at the rate paid by Kaiser under its contract with the provider, or the rate negotiated and paid by Kaiser. Kaiser may elect to enter into a contract with CalOptima providers that have reciprocity requirements, in which case, CalOptima will reprice the claim at the contracted reciprocal rate.

4. Repricing Results and Reconciliation

a. CalOptima shall notify Kaiser of the results within thirty (30) business days after the date of CalOptima's receipt of the complete claims paid file.

b. Kaiser shall provide a rebuttal to, or acceptance of, the results within thirty (30) business days after the date of receipt of the results.

c. CalOptima, with the cooperation of Kaiser, shall perform a reconciliation of paid covered service expenses, if necessary.

d. CalOptima shall issue payment to Kaiser within fifteen (15) business days after receipt of the repricing acceptance or the completion of the reconciliation.

e. In the event that Kaiser is still dissatisfied with the repricing after rebuttal, reconciliation, and payment, then Kaiser shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Policy HH.1101 CalOptima Provider Complaint.

## IV. ATTACHMENT(S)

Not Applicable

## V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy FF.1001: Capitation Payments
D. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
E. CalOptima Policy FF.1007: Health Network Reinsurance Coverage
F. CalOptima Policy HH.1101: CalOptima Provider Complaint

## VI. REGULATORY AGENCY APPROVAL(S)

None to Date

## VII. BOARD ACTION(S)

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| Date | Meeting |
|---|---|
| 08/02/2018 | Regular Meeting of the CalOptima Board of Directors |
| 10/04/2018 | Regular Meeting of the CalOptima Board of Directors |

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2 **VIII. REVISION HISTORY**
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| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 07/01/2019 | FF.4000 | Whole-Child Model – Financial Reimbursement for Capitated Health Networks | Medi-Cal |

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1 **IX. GLOSSARY**
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| Term | Definition |
|---|---|
| Aid Code | The two (2) character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services. |
| California Children's Services (CCS) Program | The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9. |
| CalOptima Direct-Administrative | The managed Fee-For-Service health care program operated by CalOptima that provides services to Members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct |
| CalOptima Medi-Cal Fee Schedule | Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible. |
| Capitation Rate | The per capita rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age, and gender. |
| Capitation Payment | The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender. |
| Contract for Health Care Services | The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Cared Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract. |
| 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. |
| Division of Financial Responsibility (DOFR) | A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange |
| Health Maintenance Organization (HMO) | A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code. |
| Health Network | A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members enrolled to that Health Network. |

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| Term | Definition |
|---|---|
| Member | A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program. |
| Measurement Period | Fiscal year July 1 to June 30. |
| Open Measurement Period | The measurement year will remain open until the third annual report is issued to health network |
| Physician Hospital Consortium (PHC) | A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services. |
| Primary Hospital | A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC). |
| Primary Physician Group | A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC). |
| Shared Risk Group | A Health Network who accepts delegated clinical and financial responsibility for professional services for enrolled Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services. |

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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**

3. Consider Actions Related to CalOptima's Medi-Cal Whole-Child Model Program Provider Payment Methodology

**Contact**

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

**Recommended Actions**

Approve provider payment methodology for the CalOptima Medi-Cal Whole-Child Model (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 will implement the WCM program on a phased-in basis, with implementation for Orange County scheduled to begin no sooner than January 1, 2019. CalOptima will assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorization activities, claims management (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for Neonatal Intensive Care Unit (NICU) services. The Orange County Health Care Agency (OC HCA) will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members, including individuals who exceed the Medi-Cal income thresholds and undocumented children who transition out of CalOptima when they turn 18 years old. OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

In order to ensure compliance with regulatory requirements, CalOptima will refer to SB 586, guidance issued by DHCS through All Plan Letters (APL), plan contract amendments and readiness requirements, and CCS requirements published in the CCS Numbered Letters. Previously, CCS was carved-out of CalOptima's Medi-Cal MCP contract. As such, CalOptima CCS services were not included in the existing delivery model or health network contracts. CalOptima members receiving

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CCS services were enrolled with CalOptima Direct (COD), CalOptima's Community Network (CCN), or other contracted health networks.

To meet the goals of the WCM, beginning January 1, 2019, CalOptima plans to allow members receiving CCS services to remain enrolled with either CalOptima's Community Network or other contracted CalOptima health networks. CalOptima will delegate CCS services to health networks according to the current health network models. The three health network models include Health Maintenance Organization (HMO), Physician-Hospital Consortium (PHC), or Shared-Risk Group (SRG).

**Discussion**

DHCS Capitation Rates

CalOptima received draft Fiscal Year (FY) 2018-19 (effective January 2019 – June 2019) capitation rates from DHCS on April 27, 2018. The rates reflect reimbursement for both CCS and non-CCS services. CalOptima will continue to monitor the sufficiency of the WCM rates, and work closely with DHCS to ensure adequate Medi-Cal revenue to support the new program.

Projected Medical Costs

Staff has analyzed high-level data on the transitioning CCS-eligible group provided by the State. Generally, the transitioning group appears to incur extensive medical costs that are highly variable and volatile. In addition, the WCM population is relatively small, which reduces the ability to spread high cost cases across a larger enrollment. CalOptima has limited experience data available to forecast medical expenses and to make definitive assessments of potential financial risks.

Provider Payment Model

In order to mitigate potential financial risks to the health networks resulting from the implementation of the WCM program, CalOptima recommends creating a new provider reimbursement methodology specific to the WCM population, as summarized below. The goal of the new reimbursement methodology is to reduce the likelihood of unreasonable financial burdens on health networks due to potentially high costs for the WCM population. The following sections describe CalOptima's proposed WCM provider reimbursement by network arrangement type.

CalOptima Direct Networks (COD/CCN)

For direct fee-for-service providers, reimbursement will depend on whether the providers are contracted with CalOptima and whether they are paneled to provide CCS services.

For non-professional services, including hospital and ancillary, CalOptima will pay contracted providers at the contracted rate for both CCS and non-CCS members. CalOptima will reimburse non-contracted providers at 100% of the designated Medi-Cal payment rates.

For professional specialist services, CalOptima will continue to reimburse providers under the current CCS payment policy. Providers who are CCS paneled, whether they are contracted or non-contracted, will be reimbursed at 140% of the Medi-Cal Fee Schedule for all services provided to members under 21.

| Service Type | Contracted Provider | Non-Contracted Provider |
|---|---|---|
| Hospital & Ancillary | Contracted Rates | 100% of CalOptima Medi-Cal Fee Schedule |
| PCP | Contracted Rates | 100% of CalOptima Medi-Cal Fee Schedule |
| CCS Paneled Specialist | 140% of CalOptima Medi-Cal Fee Schedule | 140% of CalOptima Medi-Cal Fee Schedule |
| Non-CCS Paneled Specialist | Contracted Rates | 100% of CalOptima Medi-Cal Fee Schedule |

Delegated Health Networks (HMO/PHC/SRG)
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. To develop the initial capitation rate, CalOptima will employ the following methods:

- Establish estimated professional and hospital capitation rates that are consistent with DHCS' pricing methodology and include payments for CCS and non-CCS services;
- Align the service category pricing as closely as possible to the contracted division of financial responsibility associated with each health network and hospital;
- Carve out financial risk from the capitation rate for prescription drugs, managed long-term services and supports, and high cost conditions, including but not limited to members diagnosed with hemophilia, members in treatment for end stage renal disease (ESRD), members receiving an organ transplant, and maintenance and transportation costs for specific cases requiring special arrangements;
- Exclude projected expenses from the capitation rate for catastrophic cases. CalOptima will reimburse expenses to delegated health networks and hospitals through an interim catastrophic reimbursement process and risk corridor settlement;
- Apply blended capitation rates developed across all members and that are not separated into different age/gender bands. However, CalOptima will apply an age/gender factor by health network to adjust for cost variances due to the enrollment mix;
- Apply acuity risk factors to adjust for cost variances due to medical acuity; and
- Include an administration load to the both the professional and hospital capitation rates to address administrative expenses and medical management. The proposed 6.6% administration load is consistent the amount DHCS applies to CalOptima's WCM capitation rate. As proposed, CalOptima will keep this percentage fixed to ensure that health networks and hospitals are adequately compensated for the expenditures required to implement and manage the WCM program.

CalOptima 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, CalOptima will implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases and (2) Retrospective risk corridor.

1) Interim Reimbursement for Catastrophic Cases: The purpose of providing interim catastrophic reimbursement payments is to mitigate potential cash flow shortfalls due to the occurrence of high cost cases. CalOptima proposes implementing the following process to reimburse delegated health networks and hospitals for catastrophic cases to supplement their monthly capitation payments:

    - Reimbursement will be determined by the total delegated medical costs incurred for a given member within a given reconciliation period. If the total delegated medical costs for a given member exceed a prescribed threshold, CalOptima will reimburse the provider for the costs in excess of the threshold;
    - CalOptima will evaluate professional expenses and hospital expenses for a given member separately and will apply CalOptima's existing reinsurance thresholds of $17,000 per member per year for professional expenses and $150,000 per member per year for hospital expenses. CalOptima will not apply a coinsurance level to members in the WCM program;
    - Networks will be required to submit complete and accurate payment data to substantiate all incurred expenses. Payment data will be validated and repriced, similar to CalOptima's existing reinsurance reimbursement process; and
    - Initially, CalOptima will process the interim catastrophic reimbursement on a quarterly basis to minimize cash flow issues for health networks and hospitals. However, CalOptima may adjust the frequency of the reimbursement process in the event a health network or hospital requires reimbursement on a more timely basis.

2) Retrospective Risk Corridor: CalOptima will implement a retrospective risk corridor to better align health network and hospital capitation to their incurred costs. Risk corridors can serve as a safety net for providers that incur a high level of expenses relative to the capitation that they receive. CalOptima will work with health networks and hospitals to construct risk corridor parameters that provide adequate compensation, while still maintaining a reasonable financial incentive to efficiently manage utilization and costs. The risk corridor will be based on the following parameters:

    - Risk corridors will only apply to the medical component (excludes medical management and administration expenses) of the WCM capitation rate;
    - The prospective capitation rate will be used as the basis for the risk corridor reconciliation. CalOptima will also account for funding previously paid through the interim catastrophic reimbursement payment process during the reconciliation process;
    - The number of risk corridors applied and the range of each will be determined from an evaluation of projected risk to the delegated health networks and hospitals. Risk corridors will be set at levels that were projected to achieve an optimal balance that provides sufficient risk mitigation and financial incentives for providers;
    - Each risk corridor will have an associated percentage that splits risk between CalOptima and the provider. Similarly, risk sharing will be set at levels that achieve an optimal balance that provides sufficient risk mitigation and financial incentives for providers. The following table gives the proposed risk corridor ranges and risk sharing percentages:

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| Medical Loss Ratio Threshold | CalOptima's Risk/Surplus Share | Description |
|---|---|---|
| > 115% | 95% | CalOptima will reimburse 95% of incurred medical expenses that are >115% |
| >105% to ≤ 115% | 90% | CalOptima will reimburse 90% of incurred medical expenses that are >105% and ≤ 115% |
| >102% to ≤ 105% | 75% | CalOptima will reimburse 75% of incurred medical expenses that are >102% and ≤ 105% |
| >100% to ≤ 102% | 50% | CalOptima will reimburse 50% of incurred medical expenses that are >100% and ≤ 102% |
| 100% | 0% | No change in reimbursement |
| < 100% to ≥ 98% | 50% | CalOptima will recoup 50% of capitation if medical expenses are <100% and ≥ 98% |
| < 98% to ≥ 95% | 75% | CalOptima will recoup 75% of capitation if medical expenses are <98% and ≥ 95% |
| < 95% to ≥ 85% | 90% | CalOptima will recoup 90% of capitation if medical expenses are <95% and ≥ 85% |
| < 85% | 100% | CalOptima will recoup 100% of capitation if medical expenses are <85% |

* Risk corridor will be evaluated from the medical component of the capitation rate.

- For SRG and PHC networks, risk corridor reconciliations will be evaluated separately for each capitation type (e.g. professional capitation and hospital capitation). For HMO health networks, risk corridor reconciliations will be evaluated against total capitation, which may include professional, hospital, pharmacy, or other delegated services, if applicable; and
- Risk corridor reconciliations will be performed on a calendar year basis, beginning with the period from January 1, 2019, to December 31, 2019. CalOptima may adjust the frequency as more experience becomes available. Each annual reconciliation report shall include refreshed reports from the previous two (2) annual settlement periods. After two (2) years, the refreshed report shall be considered final.

**Fiscal Impact**

Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. 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. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Considering the limited data available on the CCS population, the volatility associated with the cost of providing their care, and the protections being proposed for the health networks, the underlying

assumption behind the staff recommendation is that the state will ensure that the program is adequately funded. If this assumption were to prove inaccurate, the program could potentially represent significant economic downside to CalOptima.

**Rationale for Recommendation**
The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of CCS to the WCM, and to mitigate financial risks to our delegated health networks and hospitals.

**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**
None

*/s/ Michael Schrader* *7/25/2018*
**Authorized Signature** **Date**

# CalOptima Board Action Agenda Referral

**Action To Be Taken October 4, 2018**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**

7. Consider Revisions and Development of CalOptima Financial Policies and Procedures Related to the Whole-Child Model Program and Annual Policy Review

**Contact**

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

**Recommended Actions**

Authorize the Chief Executive Officer (CEO) to revise and develop new Medi-Cal financial policies and procedures in conjunction with the Whole-Child Model (WCM) program:

1. FF.1007: Health Network Reinsurance Coverage;
2. FF.1009: Health-based Risk Adjusted Capitation Payment System;
3. FF.1010: Shared Risk Pool; and
4. FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks.

**Background**

CalOptima has established an annual policy review process by which policies and procedures are updated and subject to peer review. In addition to this annual review, CalOptima revises and develops policies and procedures, as needed, to implement new programs, or comply with federal and state law and regulations, contracts, and business practices.

Effective January 1, 2019, CalOptima will integrate California Children's Services (CCS) into its Medi-Cal managed care plan through the Whole-Child Model (WCM) program. At its June 7, 2018, meeting, the CalOptima Board of Directors (Board) authorized the execution of an Amendment to the Primary Agreement between the California Department of Health Care Services (DHCS) and CalOptima with respect to implementation of the WCM program. Primary guidance is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016 and the state All Plan Letter (APL) 18-011 released on June 28, 2018. In addition, DHCS has provided additional reporting requirements and implementation deliverables.

To meet the requirements of the WCM program by January 1, 2019, CalOptima will allow members receiving CCS services to remain enrolled either in CalOptima's Community Network or in a contracted health network. CalOptima will delegate CCS services to health networks according to their current health network models. The three health network models include Health Maintenance Organization (HMO), Physician-Hospital Consortium (PHC), or Shared-Risk Group (SRG).

**Discussion**

At its August 2, 2018, the Board approved actions related to the WCM provider payment methodology. The following provides additional information on the revised and developed policies:

1. FF.1007: Health Network Reinsurance Coverage addresses CalOptima's reinsurance coverage for health networks, excluding any Health Maintenance Organizations (HMOs) that are

financially at risk for catastrophic claims. During the annual policy review process, staff revised the policy to exclude claims for members eligible for CCS.

2. FF.1009: Health-based Risk Adjusted Capitation Payment System outlines the process for CalOptima's health-based risk adjusted capitation payment system. Effective January 1, 2019, members who are eligible for services under the CCS program will not qualify for risk adjustment under this policy. During the annual policy review, staff revised the policy to update the definitions section and to ensure current operational procedures are aligned with the upcoming policy change.

3. FF.1010: Shared Risk Pool outlines the process for CalOptima's administration of the Shared Risk Pool with a Shared Risk Group. Staff revised the policy to exclude amounts for health network assigned members who are eligible for services under the CCS program.

4. FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks establishes the reimbursement process for CalOptima to distribute WCM payments timely and accurately to health networks. This new policy describes the methodology to calculate and adjust WCM payments, defines the measurement period for WCM payments, describes the types of payments for each measurement period, and gives payment distribution timelines.

**Fiscal Impact**

The recommended action to revise and develop new Medi-Cal policies and procedures in conjunction with the WCM program is a budgeted item, with no anticipated additional fiscal impact. Management has included projected medical and administrative expenses associated with the WCM program and the annual policy reviews in the CalOptima Fiscal Year 2018-19 Operating Budget approved by the Board on June 7, 2018.

**Rationale for Recommendation**

The recommended action will ensure CalOptima's policies and procedures are established to comply with state requirements for the WCM program.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. FF.1007: Health Network Reinsurance Coverage
2. FF.1009: Health-based Risk Adjusted Capitation Payment System
3. FF.1010: Shared Risk Pool
4. FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Members
5. Board Action dated August 2, 2018, Consider Actions Related to CalOptima's Medi-Cal Whole-Child Model Program Provider Payment Methodology
6. DHCS All Plan Letter 18-011 California Children's Services Whole Child Model Program

*/s/ Michael Schrader* | *9/26/2018*
**Authorized Signature** | **Date**

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Policy #: FF.1007~~-2017-2018~~
Title: **Health Network Reinsurance Coverage**
Department: Finance
Section: Not Applicable

CEO Approval: Michael Schrader _______

Effective Date: 07/01/10
Last Review Date: ~~07~~09/~~01~~06/~~17~~18
Last Revised Date: ~~07~~09/~~01~~06/~~17~~18

1 **I. PURPOSE**
2
3 This policy sets forth CalOptima's reinsurance coverage for Health Networks, excluding any Health
4 Maintenance Organizations (HMOs) that are financially at-risk for catastrophic claims.
5
6 **II. POLICY**
7
8 A. CalOptima shall provide reinsurance coverage to its eligible Health Networks, in accordance with
9 this policy.
10
11 B. Effective January 1, 2019, claims for services to Members eligible for California Children's
12 Services (CCS) Program shall be excluded from this policy.
13
14 ~~B.~~C. The coverage period for this policy is each CalOptima fiscal year beginning ~~12:01~~12:00 a.m.
15 Pacific Standard Time (PST~~),~~) July 1~~, 2017,~~ through ~~12:00 a.m.~~11:59 p.m. PST~~,~~ June 30~~, 2018~~.
16
17 ~~C.~~D. Reinsurance coverage applies to claims incurred within the coverage period, and paid by the
18 eligible Health Network no later than six (6) months after the end of the coverage period.
19
20 ~~D.~~E. An eligible Health Network shall submit reinsurance claims to CalOptima no later than
21 December 31~~, 2018~~ following the end of the previous fiscal year to be eligible for reimbursement:
22
23 1. An eligible HMO may submit reinsurance claims for covered hospital and covered physician
24 expenses;
25
26 2. A Primary Physician Group may submit reinsurance claims for covered physician expenses;
27
28 3. A Primary Hospital may submit reinsurance claims for covered hospital expenses; and
29
30 4. A Shared Risk Group (SRG) may submit reinsurance claims for covered physician expenses.
31
32 ~~E.~~F. CalOptima shall identify reinsurance claims and payment of benefits for hospital expenses for
33 Members assigned to an SRG, in accordance with CalOptima Policy FF.1010: Shared Risk Pool.
34
35 ~~F.~~G. Covered expenses include those Covered Services that are delegated to an eligible Health
36 Network, and Shared Risk services, as defined in the Division of Financial Responsibility (DOFR)
37 between CalOptima and the eligible Health Network, except those services listed in Section II.~~G~~H
38 of this policy.
39

1. Covered hospital expenses are either:

   a. Those Covered Services listed in the DOFR between CalOptima and a Primary Hospital in the Contract for Health Care Services – Hospital; or

   b. Those Covered Services listed in the DOFR between CalOptima and an eligible HMO in the Contract for Health Care Services; or

   c. Shared Risk services listed in the DOFR between CalOptima and a Shared Risk Group in the Contract for Health Care Services – Physician (Shared Risk).

2. Covered physician expenses are either:

   a. Those Covered Services listed in the DOFR between CalOptima and a Primary Physician Group in the Contract for Health Care Services – Physician; or

   b. Those Covered Services listed in the DOFR between CalOptima and an eligible HMO in the Contract for Health Care Services; or

   c. Shared Risk services listed in the DOFR between CalOptima and a Shared Risk Group in the Contract for Health Care Services – Physician (Shared Risk).

G.H. Covered expenses exclude Capitation Payments, and any other non-Covered Service, exclusion, or Covered Service that is not a Shared Risk service that is the financial responsibility of CalOptima. This includes covered Transplant services, and Health Network Transplant claims denied for payment due to administrative reasons (e.g., timeliness).

H.I. Covered expenses are subject to the following limitations:

1. Hospital services:

   a. For contracted hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, billed charges, or the Contracted CalOptima Direct (COD) Hospital Rate, averaged over the entire length of stay or stays.

   b. For non-contracted hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, billed charges, or the non-contracted COD hospital rate, averaged over the entire length of stay or stays.

      i. For non-contracted emergency hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, or billed charges, averaged over the entire length of stay or stays, up to the amount specified for non-contracted emergency hospital inpatient services in CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

      ii. For non-contracted post-stabilization inpatient services, up to the amount specified for non-contracted post-stabilization inpatient services, in accordance with CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group; and Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative

Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

iii. For non-contracted out-of-state emergency hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, or billed charges, averaged over the entire length of stay or stays, up to the All Patient Refined Diagnosis-Related Groups (APR-DRG) paid by Medi-Cal Fee-For-Service for out-of-State hospital inpatient services.

c. All calculations shall be made prior to the application of Deductible or coinsurance. CalOptima shall accept a completed UB-04 form as proof of payment for capitated hospital services. A hospital shall not include any loss for home health services or outpatient services, or for days of confinement in an extended care facility or rehabilitation facility.

2. Physician services:

a. The lesser of the amount paid for covered physician expenses or:

i. One hundred twenty-nine percent (129%) of the current CalOptima Medi-Cal Fee Schedule in effect on the date of service; or

ii. Fifty percent (50%) of the amount paid if Medi-Cal has no value for the five-digit numerical Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, or other code as assigned by the Department of Health Care Services (DHCS).

b. The above calculation shall be made prior to the application of Deductible or coinsurance. CalOptima shall accept a completed CMS-1500 form as proof of payment for capitated physician services.

3. Hemodialysis services: Limited to one thousand dollars ($1,000) per calendar day.

4. Chemotherapy drugs and related services: Limited to one thousand dollars ($1,000) per calendar day.

5. In the absence of other limitations, CalOptima shall calculate covered expenses by summing all hospital or physician covered expenses per Member per coverage period, as applicable by Section II.~~D~~E of this policy, subject to the annual Deductible.

~~I.~~J. Annual Deductibles are as follows:

1. Hospital Deductible:

a. One hundred fifty thousand dollars ($150,000) of covered hospital expenses per Member during the coverage period.

b. Subject to the terms of this policy, CalOptima shall reimburse eighty percent (80%) of the expenses after a Deductible of one hundred fifty thousand dollars ($150,000) is applied.

2. Physician Deductible:

a. Seventeen thousand dollars ($17,000) of covered physician expenses per Member during the coverage period.

b. Subject to the terms of this policy, CalOptima shall reimburse eighty percent (80%) of the expenses after a Deductible of seventeen thousand dollars ($17,000) is applied.

~~J.~~K. The maximum reinsurance amount payable under this policy for covered expenses for a Member is calculated on the basis of one million dollars ($1,000,000) of coverage per Member per coverage period, minus the applicable annual Deductible and coinsurance, and subject to any limitations noted in this policy.

## III. PROCEDURE

A. Process to submit reinsurance claims for covered expenses, except hospital expenses for a Member assigned to a Shared Risk Group:

1. An eligible Health Network shall submit reinsurance claims on a quarterly basis, no later than the twentieth (20th) calendar day of the month following the end of a quarter.

2. An eligible Health Network shall submit reinsurance claims using CalOptima's proprietary format and file naming convention, as described in the Reinsurance Field Names and Values for Electronic File Transmission. An eligible Health Network may submit the reinsurance claims file by transmitting an encrypted electronic mail to reinsurance@caloptima.org, submitting electronically to CalOptima's secure FTP site, or by mailing an encrypted Universal Serial Bus (USB) flash drive, compact disk (CD) or Digital Versatile Disc (DVD) to:

   Attention: Coding Initiatives Department—Reinsurance Claims
   CalOptima
   505 City Parkway West
   Orange, CA 92868

3. Reinsurance claims shall include:

   a. Claims paid by an eligible Health Network during that quarter only; or

   b. Claims detail for qualified Members who reached the annual Deductible.

4. Upon request, an eligible Health Network shall provide detailed support, within ten (10) business days, for any individual claim for which billed charges are greater than, or equal to, ten thousand dollars ($10,000), including copies of the claim form, cancelled check, explanation of benefits (EOB), Remittance Advice Detail (RAD), and other information, as requested by CalOptima. All non-contracted emergency hospital inpatient claims require submission of the authorization distinguishing days considered emergency and post-stabilization.

5. CalOptima shall notify an eligible Health Network of file acceptance or rejection within ten (10) business days after receipt.

   a. CalOptima may reject a file for any missing information or incorrect data.

   b. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days from receipt of notification from CalOptima.

6. CalOptima shall provide an eligible Health Network with detailed reports of claims processed within forty-five (45) business days after the quarter end submission date.

7. An eligible Health Network may appeal claim denials and underpayments within sixty (60) business days after the date of CalOptima's RAD.

   a. The eligible Health Network shall submit a request for appeal, in writing, to CalOptima at reinsurance@caloptima.org or by U.S. mail to:

      Attention: Coding Initiatives Department—Reinsurance Claims
      CalOptima
      505 City Parkway West
      Orange, CA 92868

   b. The eligible Health Network shall submit the appeals claims submission file in the same format as the initial claims submission, in accordance with the Reinsurance Field Names and Values for Electronic File Transmission.

   c. An appeals claims submission file shall only include specific claims to be reconsidered.

   d. The eligible Health Network shall provide detailed claims support for each claim, including copies of the claim form, cancelled check, EOB, RAD, or any other information, as requested by CalOptima.

   e. CalOptima shall notify the eligible Health Network of file acceptance or rejection within ten (10) business days after receipt of the appeal file.

      i. CalOptima may reject a file for any missing information or incorrect data.

      ii. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days after receipt of notification from CalOptima.

   f. CalOptima shall process an appeal and provide an eligible Health Network with detailed reports within forty-five (45) business days after receipt of the appeal.

B. If a loss exceeds, or is expected to exceed, the annual Deductible by ten thousand dollars ($10,000), CalOptima may appoint CalOptima staff to represent CalOptima's interest in the ongoing administration of the loss. An eligible Health Network shall cooperate with CalOptima staff in the ongoing administration of the loss.

C. In the event of termination of the Contract for Health Care Services between an eligible Health Network and CalOptima, the coverage period shall end three (3) months after the termination date. A terminated eligible Health Network shall submit reinsurance claims no later than six (6) months after the termination date in order to receive reimbursement.

D. An eligible Health Network shall make books and records available to CalOptima for inspection and audit at any time during normal business hours in accordance with the Contract for Health Care Services.

## IV. ATTACHMENTS

1
2 A. Reinsurance Field Names and Values for Electronic File Transmission
3
4 **V. REFERENCES**
5
6 A. Contract for Health Care Services
7 B. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima
8 Direct or a Member Enrolled in a Shared Risk Group
9 C. CalOptima Policy FF.1007_2016-2017-2018: Health Network Reinsurance Coverage
10 D. CalOptima Policy FF.1010: Shared Risk Pool
11 E. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima
12 Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled
13 in a Shared Risk Group
14 F. CalOptima Policy FF.3001: Financial Reporting
15 G. Title 42, United States Code, Section 1396u-2(b)(2)(D)
16 H. This policy supersedes:
17 1. CalOptima Financial Bulletin #7: Policy FF.1101: Excess Risk Liability Program
18 2. CalOptima Financial Bulletin #32: Revisions to FF.1200: Health Network Reinsurance
19 Coverage
20 3. CalOptima Financial Bulletin #34: Revisions to FF.1200: Health Network Reinsurance
21 Coverage
22 4. CalOptima Financial Bulletin #35: Health Network Reinsurance Program for SPD over Age 45
23
24 **VI. REGULATORY AGENCY APPROVALS**
25
26 A. 08/06/15: Department of Health Care Services
27 B. 12/10/10: Department of Health Care Services
28
29 **VII. BOARD ACTIONS**
30
31 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
32 A.B. 06/01/17: Regular Meeting of the CalOptima Board of Directors Regular CalOptima
33 Board of Directors Meeting
34 B.C. 10/01/09: Regular Meeting of the CalOptima Board of Directors Regular CalOptima
35 Board of Directors Meeting
36 C.D. 09/17/09: Special Meeting of the CalOptima Board of Directors' Finance Committee
37 D.E. 09/04/08: RegRegular Meeting of the CalOptima Board of Directors ular CalOptima
38 Board of Directors Meeting
39 E. 09/11/07: Regular Meeting of the CalOptima Board of Directors Regular CalOptima Board of
40 Directors Meeting
41 F.
42 F.
43 **VIII. REVIEW/REVISION HISTORY**
44

| Version | Version Date | Policy Number | Policy Title | Line(s) of Business |
|---|---|---|---|---|
| Effective | 07/01/2010 | FF.1007_2009-2010 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 07/01/2011 | FF.1007_2010-2011 | Health Network Reinsurance Coverage | Medi-Cal |

| Version | Version Date | Policy Number | Policy Title | Line(s) of Business |
|---|---|---|---|---|
| Revised | 03/01/2012 | FF.1007_2011-2012 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 10/01/2012 | FF.1007_2012-2013 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 12/01/2013 | FF.1007_2013-2014 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 04/01/2015 | FF.1007_2014-2015 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 02/01/2016 | FF.1007_2015-2016 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 07/01/2016 | FF.1007_2016-2017 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 07/01/2017 | FF.1007_2017-2018 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 09/06/2018 | FF.1007 | Health Network Reinsurance Coverage | Medi-Cal |

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1 **IX. GLOSSARY**
2

| 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. |
| California Children's Services (CCS) Eligible Condition | Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae. |
| 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. |
| 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), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. |
| Deductible | For purposes of this policy, the amount set forth in Section III.I of this policy, which the eligible Health Network must pay in eligible expenses on behalf of a Member during the coverage period, before CalOptima is responsible for reimbursing the eligible Health Network eighty percent (80%) of eligible expenses for that Member. |
| Division of Financial Responsibility (DOFR) | A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange. |
| Health Maintenance Organization (HMO) | A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code. |



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| Term | Definition |
|---|---|
| Health Network | A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. |
| Member | A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program. |
| Primary Hospital | A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC). |
| Primary Physician Group | A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC). |
| Shared Risk Group | A Health Network that accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services. |

1

Policy #: FF.1007
Title: **Health Network Reinsurance Coverage**
Department: Finance
Section: Not Applicable

CEO Approval: Michael Schrader _______

Effective Date: 07/01/10
Last Review Date: 09/06/18
Last Revised Date: 09/06/18

DRAFT

## I. PURPOSE

This policy sets forth CalOptima's reinsurance coverage for Health Networks, excluding any Health Maintenance Organizations (HMOs) that are financially at-risk for catastrophic claims.

## II. POLICY

A. CalOptima shall provide reinsurance coverage to its eligible Health Networks, in accordance with this policy.

B. Effective January 1, 2019, claims for services to Members eligible for California Children's Services (CCS) Program shall be excluded from this policy.

C. The coverage period for this policy is each CalOptima fiscal year beginning 12:00 a.m. Pacific Standard Time (PST) July 1 through 11:59 p.m. PST June 30.

D. Reinsurance coverage applies to claims incurred within the coverage period, and paid by the eligible Health Network no later than six (6) months after the end of the coverage period.

E. An eligible Health Network shall submit reinsurance claims to CalOptima no later than December 31 following the end of the previous fiscal year to be eligible for reimbursement:

1. An eligible HMO may submit reinsurance claims for covered hospital and covered physician expenses;

2. A Primary Physician Group may submit reinsurance claims for covered physician expenses;

3. A Primary Hospital may submit reinsurance claims for covered hospital expenses; and

4. A Shared Risk Group (SRG) may submit reinsurance claims for covered physician expenses.

F. CalOptima shall identify reinsurance claims and payment of benefits for hospital expenses for Members assigned to an SRG, in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

G. Covered expenses include those Covered Services that are delegated to an eligible Health Network, and Shared Risk services, as defined in the Division of Financial Responsibility (DOFR) between CalOptima and the eligible Health Network, except those services listed in Section II.H of this policy.

1. Covered hospital expenses are either:

   a. Those Covered Services listed in the DOFR between CalOptima and a Primary Hospital in the Contract for Health Care Services – Hospital; or

   b. Those Covered Services listed in the DOFR between CalOptima and an eligible HMO in the Contract for Health Care Services; or

   c. Shared Risk services listed in the DOFR between CalOptima and a Shared Risk Group in the Contract for Health Care Services – Physician (Shared Risk).

2. Covered physician expenses are either:

   a. Those Covered Services listed in the DOFR between CalOptima and a Primary Physician Group in the Contract for Health Care Services – Physician; or

   b. Those Covered Services listed in the DOFR between CalOptima and an eligible HMO in the Contract for Health Care Services; or

   c. Shared Risk services listed in the DOFR between CalOptima and a Shared Risk Group in the Contract for Health Care Services – Physician (Shared Risk).

H. Covered expenses exclude Capitation Payments, and any other non-Covered Service, exclusion, or Covered Service that is not a Shared Risk service that is the financial responsibility of CalOptima. This includes covered Transplant services, and Health Network Transplant claims denied for payment due to administrative reasons (e.g., timeliness).

I. Covered expenses are subject to the following limitations:

1. Hospital services:

   a. For contracted hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, billed charges, or the Contracted CalOptima Direct (COD) Hospital Rate, averaged over the entire length of stay or stays.

   b. For non-contracted hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, billed charges, or the non-contracted COD hospital rate, averaged over the entire length of stay or stays.

      i. For non-contracted emergency hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, or billed charges, averaged over the entire length of stay or stays, up to the amount specified for non-contracted emergency hospital inpatient services in CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

      ii. For non-contracted post-stabilization inpatient services, up to the amount specified for non-contracted post-stabilization inpatient services, in accordance with CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group; and Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative

1 Members, CalOptima Community Network Members, or Members Enrolled in a
2 Shared Risk Group.
3
4 iii. For non-contracted out-of-state emergency hospital inpatient services, the lesser of
5 the amount paid for covered hospital expenses, the negotiated rate, or billed charges,
6 averaged over the entire length of stay or stays, up to the All Patient Refined
7 Diagnosis-Related Groups (APR-DRG) paid by Medi-Cal Fee-For-Service for out-of-
8 State hospital inpatient services.
9
10 c. All calculations shall be made prior to the application of Deductible or coinsurance.
11 CalOptima shall accept a completed UB-04 form as proof of payment for capitated hospital
12 services. A hospital shall not include any loss for home health services or outpatient
13 services, or for days of confinement in an extended care facility or rehabilitation facility.
14
15 2. Physician services:
16
17 a. The lesser of the amount paid for covered physician expenses or:
18
19 i. One hundred twenty-nine percent (129%) of the current CalOptima Medi-Cal Fee
20 Schedule in effect on the date of service; or
21
22 ii. Fifty percent (50%) of the amount paid if Medi-Cal has no value for the five-digit
23 numerical Current Procedural Terminology (CPT) code, Healthcare Common
24 Procedure Coding System (HCPCS) code, or other code as assigned by the
25 Department of Health Care Services (DHCS).
26
27 b. The above calculation shall be made prior to the application of Deductible or coinsurance.
28 CalOptima shall accept a completed CMS-1500 form as proof of payment for capitated
29 physician services.
30
31 3. Hemodialysis services: Limited to one thousand dollars ($1,000) per calendar day.
32
33 4. Chemotherapy drugs and related services: Limited to one thousand dollars ($1,000) per calendar
34 day.
35
36 5. In the absence of other limitations, CalOptima shall calculate covered expenses by summing all
37 hospital or physician covered expenses per Member per coverage period, as applicable by
38 Section II.E of this policy, subject to the annual Deductible.
39
40 J. Annual Deductibles are as follows:
41
42 1. Hospital Deductible:
43
44 a. One hundred fifty thousand dollars ($150,000) of covered hospital expenses per Member
45 during the coverage period.
46
47 b. Subject to the terms of this policy, CalOptima shall reimburse eighty percent (80%) of the
48 expenses after a Deductible of one hundred fifty thousand dollars ($150,000) is applied.
49
50 2. Physician Deductible:
51

a. Seventeen thousand dollars ($17,000) of covered physician expenses per Member during the coverage period.

b. Subject to the terms of this policy, CalOptima shall reimburse eighty percent (80%) of the expenses after a Deductible of seventeen thousand dollars ($17,000) is applied.

K. The maximum reinsurance amount payable under this policy for covered expenses for a Member is calculated on the basis of one million dollars ($1,000,000) of coverage per Member per coverage period, minus the applicable annual Deductible and coinsurance, and subject to any limitations noted in this policy.

## III. PROCEDURE

A. Process to submit reinsurance claims for covered expenses, except hospital expenses for a Member assigned to a Shared Risk Group:

1. An eligible Health Network shall submit reinsurance claims on a quarterly basis, no later than the twentieth (20th) calendar day of the month following the end of a quarter.

2. An eligible Health Network shall submit reinsurance claims using CalOptima's proprietary format and file naming convention, as described in the Reinsurance Field Names and Values for Electronic File Transmission. An eligible Health Network may submit the reinsurance claims file by transmitting an encrypted electronic mail to reinsurance@caloptima.org, submitting electronically to CalOptima's secure FTP site, or by mailing an encrypted Universal Serial Bus (USB) flash drive, compact disk (CD) or Digital Versatile Disc (DVD) to:

Attention: Coding Initiatives Department—Reinsurance Claims
CalOptima
505 City Parkway West
Orange, CA 92868

3. Reinsurance claims shall include:

a. Claims paid by an eligible Health Network during that quarter only; or

b. Claims detail for qualified Members who reached the annual Deductible.

4. Upon request, an eligible Health Network shall provide detailed support, within ten (10) business days, for any individual claim for which billed charges are greater than, or equal to, ten thousand dollars ($10,000), including copies of the claim form, cancelled check, explanation of benefits (EOB), Remittance Advice Detail (RAD), and other information, as requested by CalOptima. All non-contracted emergency hospital inpatient claims require submission of the authorization distinguishing days considered emergency and post-stabilization.

5. CalOptima shall notify an eligible Health Network of file acceptance or rejection within ten (10) business days after receipt.

a. CalOptima may reject a file for any missing information or incorrect data.

b. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days from receipt of notification from CalOptima.

6. CalOptima shall provide an eligible Health Network with detailed reports of claims processed within forty-five (45) business days after the quarter end submission date.

7. An eligible Health Network may appeal claim denials and underpayments within sixty (60) business days after the date of CalOptima's RAD.

    a. The eligible Health Network shall submit a request for appeal, in writing, to CalOptima at reinsurance@caloptima.org or by U.S. mail to:

        Attention: Coding Initiatives Department—Reinsurance Claims
        CalOptima
        505 City Parkway West
        Orange, CA 92868

    b. The eligible Health Network shall submit the appeals claims submission file in the same format as the initial claims submission, in accordance with the Reinsurance Field Names and Values for Electronic File Transmission.

    c. An appeals claims submission file shall only include specific claims to be reconsidered.

    d. The eligible Health Network shall provide detailed claims support for each claim, including copies of the claim form, cancelled check, EOB, RAD, or any other information, as requested by CalOptima.

    e. CalOptima shall notify the eligible Health Network of file acceptance or rejection within ten (10) business days after receipt of the appeal file.

        i. CalOptima may reject a file for any missing information or incorrect data.

        ii. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days after receipt of notification from CalOptima.

    f. CalOptima shall process an appeal and provide an eligible Health Network with detailed reports within forty-five (45) business days after receipt of the appeal.

B. If a loss exceeds, or is expected to exceed, the annual Deductible by ten thousand dollars ($10,000), CalOptima may appoint CalOptima staff to represent CalOptima's interest in the ongoing administration of the loss. An eligible Health Network shall cooperate with CalOptima staff in the ongoing administration of the loss.

C. In the event of termination of the Contract for Health Care Services between an eligible Health Network and CalOptima, the coverage period shall end three (3) months after the termination date. A terminated eligible Health Network shall submit reinsurance claims no later than six (6) months after the termination date in order to receive reimbursement.

D. An eligible Health Network shall make books and records available to CalOptima for inspection and audit at any time during normal business hours in accordance with the Contract for Health Care Services.

## IV. ATTACHMENTS

A. Reinsurance Field Names and Values for Electronic File Transmission

1
2 **V. REFERENCES**
3
4 A. Contract for Health Care Services
5 B. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima
6 Direct or a Member Enrolled in a Shared Risk Group
7 C. CalOptima Policy FF.1007_2017-2018: Health Network Reinsurance Coverage
8 D. CalOptima Policy FF.1010: Shared Risk Pool
9 E. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima
10 Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled
11 in a Shared Risk Group
12 F. CalOptima Policy FF.3001: Financial Reporting
13 G. Title 42, United States Code, Section 1396u-2(b)(2)(D)
14 H. This policy supersedes:
15 1. CalOptima Financial Bulletin #7: Policy FF.1101: Excess Risk Liability Program
16 2. CalOptima Financial Bulletin #32: Revisions to FF.1200: Health Network Reinsurance
17 Coverage
18 3. CalOptima Financial Bulletin #34: Revisions to FF.1200: Health Network Reinsurance
19 Coverage
20 4. CalOptima Financial Bulletin #35: Health Network Reinsurance Program for SPD over Age 45
21
22 **VI. REGULATORY AGENCY APPROVALS**
23
24 A. 08/06/15: Department of Health Care Services
25 B. 12/10/10: Department of Health Care Services
26
27 **VII. BOARD ACTIONS**
28
29 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
30 B. 06/01/17: Regular Meeting of the CalOptima Board of Directors
31 C. 10/01/09: Regular Meeting of the CalOptima Board of Directors
32 D. 09/17/09: Special Meeting of the CalOptima Board of Directors' Finance Committee
33 E. 09/04/08: Regular Meeting of the CalOptima Board of Directors
34 F. 09/11/07: Regular Meeting of the CalOptima Board of Directors
35
36 **VIII. REVIEW/REVISION HISTORY**
37

| Version | Version Date | Policy Number | Policy Title | Line(s) of Business |
|---|---|---|---|---|
| Effective | 07/01/2010 | FF.1007_2009-2010 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 07/01/2011 | FF.1007_2010-2011 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 03/01/2012 | FF.1007_2011-2012 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 10/01/2012 | FF.1007_2012-2013 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 12/01/2013 | FF.1007_2013-2014 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 04/01/2015 | FF.1007_2014-2015 | Health Network Reinsurance Coverage | Medi-Cal |

| Version | Version Date | Policy Number | Policy Title | Line(s) of Business |
|---|---|---|---|---|
| Revised | 02/01/2016 | FF.1007_2015-2016 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 07/01/2016 | FF.1007_2016-2017 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 07/01/2017 | FF.1007_2017-2018 | Health Network Reinsurance Coverage | Medi-Cal |
| Revised | 09/06/2018 | FF.1007 | Health Network Reinsurance Coverage | Medi-Cal |

1

1 **IX. GLOSSARY**
2

| 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. |
| California Children's Services (CCS) Eligible Condition | Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae. |
| 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. |
| 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), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. |
| Deductible | For purposes of this policy, the amount set forth in Section III.I of this policy, which the eligible Health Network must pay in eligible expenses on behalf of a Member during the coverage period, before CalOptima is responsible for reimbursing the eligible Health Network eighty percent (80%) of eligible expenses for that Member. |
| Division of Financial Responsibility (DOFR) | A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange. |
| Health Maintenance Organization (HMO) | A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code. |

| Term | Definition |
| --- | --- |
| Health Network | A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. |
| Member | A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program. |
| Primary Hospital | A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC). |
| Primary Physician Group | A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC). |
| Shared Risk Group | A Health Network that accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services. |

1



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| Reinsurance Field Names and Values for Electronic File Transmission | | | | | |
|---|---|---|---|---|---|
| Accepted Format: Access or Excel (Excel is preferred) | | | | | |
| | | | | | |
| **Field Names** | **Descriptions** | **Data Type** | **Field Length** | **Example Entry** | **Notes** |
| **HNNumber** | Health Network Numbers | Alpha Numeric | 6 | PHC053 | It's either HMO or PHC and 3 digits for health network. For example, PHC053 |
| **MemberID** | CIN Number | Text | 9 | 99999999D | |
| **MemberName** | Member Names | Text | Up to 50 | Jane Doe | |
| **DOB** | Date of Birth | Date (mm/dd/yy) | | 05/01/62 | |
| **ClaimNo** | Claim Number | Alpha Numeric | Upto 25 | 2005042899903140 | |
| **ClaimType** | Claim Type | Text | Upto 25 | Professional | Professional |
| | | | | IP Hospital | Inpatient |
| | | | | OP Hospital | Outpatient |
| **ProviderID** | Provider License/NPI | Alpha Numeric | 12 | XXXX01250 | |
| **ProviderName** | Provider Name | Text | Up to 50 | XXXXX, MD | |
| **TIN** | Tax Idenfification Number | Text | Upto 15 | 123456789 | |
| **FrDOS** | From Date of service | Date (mm/dd/yy) | | 1/1/2006 | Specific Date of service must be entered not DOS range to avoid any denials due to duplication of service. |
| **ToDOS** | To Date of Service | Date (mm/dd/yy) | | 1/31/2006 | Specific Date of service must be entered not DOS range to avoid any denials due to duplication of service. |
| **POS** | Place of Service | Text | 2 | 21 | |
| **Procedurecode** | Procedure codes | Alpha Numeric | 5 | 80053 | |
| **Modifier** | Modifier | Alpha Numeric | 2 | 26 | 26 |
| **RevenueCode** | Revenue codes | Alpha Numeric | 3 | 270 | 270 |
| **Dx** | Diagnosis Codes | Alpha Numeric | 3 to 13 | 70715 | No period or dot in between diagnosis code |
| **Units_Days** | Units or Days | Numeric | Numeric | 10 | For Anesthesia procedure, enter converted total number of units (Anesthesia Units plus modifier units plus time units). |
| **BilledAmt** | Billed Amount | Currency | Currency | $0.00 | |
| **PaidAmt** | Paid Amount | Currency | Currency | $0.00 | |
| **CheckNumber** | Check Number | Alpha Numeric | Upto 10 | 1234567899 | |
| **CheckDate** | Check Date | Date (mm/dd/yy) | | mm/dd/yy | |
| **CAP_Ind** | Capitated Indicator | Text | 1 | Y or N | |
| **CAPAmt** | Capitated Amount | Currency | | $0.00 | |
| **Quarter** | Quarter | Text | 6 | Q12006 | This is the quarter when the file is submitted. |
| **FileName** | Naming convention | Text | 8 | 53PRQ106 | Must submit separate file per claim type (Professional and Hospital claims) (See "File Naming Convention" below). |
| **Adjustment_ind** | Adjustment indicator | Text | 1 | Y or N | New field added to identify adjustment to original claim to avoid any denials due to duplicate service. |

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| **Reinsurance Field Names and Values for Electronic File Transmission** | | | | | |
|---|---|---|---|---|---|
| **Accepted Format: Access or Excel (Excel is preferred)** | | | | | |
| | | | | | |
| **Field Names** | **Descriptions** | **Data Type** | **Field Length** | **Example Entry** | **Notes** |
| **Appeal Reason** | Appeal Reason | Text | Up to 250 | | Only applies to appeal and must include reason for the appeal. |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **File Naming Convention** | | | | **Value** | |
| 13 Character Length | | | | | |
| First 2 character is designated for HN number | | | | 53 | |
| Third character is the file type | | | | P = professional, H = Hospital | |
| Fourth character is the program/incentive | | | | R = Reinsurance | |
| Fifth to Eight character is designated as the Quarter file submission | | | | Q312 | |
| Last 5 characters are designated for the Policy Year as in "Fiscal Year" | | | | _2012 | |
| For example: UCMG professional file for Fiscal Year 2012 | | | | 67PRQ412_2012 | |
| | | | | | |
| | | | | | |
| Note: please rename file with prefix "1_FINRPT_" if submitting into FTP site | | | | 1_FINPRT_67PRQ412_2012 | |

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Policy #: FF.1009
Title: **Health~~-~~ ~~B~~based Risk Adjusted Capitation Payment System**
Department: Finance
Section: Not Applicable

CEO Approval: Michael Schrader _______

Effective Date: 07/01/08
Last Review Date: ~~05/01/17~~09/06/18
Last Revised Date: ~~05/01/17~~09/06/18

## I. PURPOSE

This policy outlines the process for CalOptima's Health-based Risk Adjusted (HRA) 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 January 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.

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

1. Has an Aged, Blind, Disabled, 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.

~~D.~~E. CalOptima shall develop a Risk Assignment Database to contain medical and diagnostic data for Members eligible for risk-adjustment pursuant to Section II.~~D~~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.

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

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

   a. Member identification number;

   b. Aid Code;

   c. Diagnosis code; 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 Member a Risk Score using CDPS and a 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 ("year 1") through November ("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 ("year 2") through May ("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.

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

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. ATTACHMENTS

Not Applicable

## V. REFERENCES

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

## VI. REGULATORY AGENCY APPROVALS

1 A. 09/30/09: Department of Health Care Services
2
3 **VII. BOARD ACTIONS**
4
5 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
6 A.B. 06/04/09: Regular Meeting of the CalOptima Board of Directors
7 B.C. 05/05/09: Regular Meeting of the CalOptima Board of Directors
8 C.D. 06/03/08: Regular Meeting of the CalOptima Board of Directors
9
10 **VIII. REVIEW/REVISION HISTORY**
11

| Version | Date | Policy Number | Policy Title | Line(s) of Business |
|---|---|---|---|---|
| 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 | 09/06/2018 | FF.1009 | Health B-based Risk Adjusted Capitation Payment System | Medi-Cal |

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1 **IX. GLOSSARY**
2

| 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. |
| 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. |

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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: | 07/01/08 |
| Last Review Date: | 09/06/18 |
| Last Revised Date: | 09/06/18 |

DRAFT

## I. PURPOSE

This policy outlines the process for CalOptima's Health-based Risk Adjusted (HRA) 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 January 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, 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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1. The Risk Assignment Database shall contain information including, but not limited to:

   a. Member identification number;

   b. Aid Code;

   c. Diagnosis code; and

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B. Calculation of Member's Risk Score

1. CalOptima or its contracted vendor shall utilize the Risk Assignment Database to assign a Member a Risk Score using CDPS and a 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 ("year 1") through November ("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 ("year 2") through May ("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.

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. ATTACHMENTS

Not Applicable

## V. REFERENCES

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

## VI. REGULATORY AGENCY APPROVALS


Back to Agenda

A. 09/30/09: Department of Health Care Services

## VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
B. 06/04/09: Regular Meeting of the CalOptima Board of Directors
C. 05/05/09: Regular Meeting of the CalOptima Board of Directors
D. 06/03/08: Regular Meeting of the CalOptima Board of Directors

## VIII. REVIEW/REVISION HISTORY

| Version | Date | Policy Number | Policy Title | Line(s) of Business |
|---|---|---|---|---|
| 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 | 09/06/2018 | FF.1009 | Health-based Risk Adjusted Capitation Payment System | Medi-Cal |

1 **IX. GLOSSARY**
2

| **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. |
| 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. |

| 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. |

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

CEO Approval: Michael Schrader _______

| | |
|---|---|
| Effective Date: | 07/01/08 |
| Last Review Date: | ~~05/01/17~~09/06/18 |
| Last Revised Date: | ~~05/01/17~~09/06/18 |

1 **I. PURPOSE**
2
3 This policy outlines the process for CalOptima's administration of the Shared Risk Pool with a Shared
4 Risk Group.
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6 **II. POLICY**
7
8 A. CalOptima shall establish a Shared Risk Pool for a Shared Risk Group in accordance with the
9 Contract for Health Care Services and the terms and conditions of this policy.
10
11 B. CalOptima shall establish a Shared Risk Pool each fiscal year (July 1 through June 30) during the
12 term of a Shared Risk Group's Contract for Health Care Services.
13
14 C. The Shared Risk Budget shall include:
15
16 1. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group
17 within the applicable period;
18
19 2. Monies recovered by CalOptima or a Provider from Coordination of Benefits for Shared Risk
20 Services provided to Members assigned to the Shared Risk Group, in accordance with
21 CalOptima Policy FF.2003: Coordination of Benefits;
22
23 3. Reinsurance recovery amounts as set forth in CalOptima Policy FF.1007: Health Network
24 Reinsurance Coverage; and
25
26 4. Supplemental OB Delivery Care payments as set forth in CalOptima Policy FF.1005f: Special
27 Payments: Supplemental OB Delivery Care Payment.
28
29 D. The Shared Risk Budget shall not include any amounts for Health Network Members eligible for the
30 California Children's Services (CCS) Program.
31
32 ~~D.~~E. Shared Risk Expenses shall include:
33
34 1. Claims paid for Shared Risk Services provided to Members assigned to the Shared Risk Group;
35
36 2. An estimate of Incurred But Not Reported (IBNR) expenses for Shared Risk Services;
37
38 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.

E.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.

F.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.

G.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.

H.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.GH.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.

~~I.~~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.

~~J.~~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.

~~K.~~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.

~~L.~~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.

~~M.~~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.

~~N.~~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.~~F~~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 ~~Section~~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 ~~Section~~Sections II.~~D~~E and II.~~E~~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 ~~Section~~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. 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. 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. 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.~~D~~E and II.~~E~~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;

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

iv. 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.

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.



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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.

   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 ~~Section~~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. 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. 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 ~~Section~~Sections II.~~D~~E and II.~~E~~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;

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

   iv. Any reinsurance premiums paid by CalOptima within that fiscal year and up to the effective date of termination 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.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



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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.

   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. ATTACHMENTS

A. Risk Pool Claims Objection Form

## V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy FF.1007: Health Network Reinsurance Coverage
C. CalOptima Policy FF.1005c: Special Payments – High Cost Exclusion Items



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D. CalOptima Policy FF.2003: Coordination of Benefits
E. CalOptima Policy FF.1005f: Special Payments: Supplemental OB Delivery Care Payment

## VI. REGULATORY AGENCY APPROVALS

A. 03/14/11: Department of Health Care Services

## VII. BOARD ACTIONS

A. ~~Not Applicable~~ 09/06/18: Regular Meeting of the CalOptima Board of Directors

## VIII. REVIEW/REVISION HISTORY

| Version | Date | Policy Number | Policy Title | Line(s) of Business |
|---|---|---|---|---|
| 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 | 09/06/2018 | FF.1010 | Shared Risk Pool | Medi-Cal |

1 **IX. GLOSSARY**
2

| 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. |
| California Children's Services (CCS) Eligible Condition | Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae. |
| 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. |
| 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:<br>Amounts paid for Shared Risk Services provided to Members assigned to the Shared Risk Group;<br>An estimate of Incurred But Not Reported (IBNR) expenses;<br>Administrative expenses at a rate established in the Contract for Health Care Services; and<br>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. |

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

CEO Approval: Michael Schrader _______

Effective Date: 07/01/08
Last Review Date: 09/06/18
Last Revised Date: 09/06/18

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1 **I. PURPOSE**
2
3 This policy outlines the process for CalOptima's administration of the Shared Risk Pool with a Shared
4 Risk Group.
5
6 **II. POLICY**
7
8 A. CalOptima shall establish a Shared Risk Pool for a Shared Risk Group in accordance with the
9 Contract for Health Care Services and the terms and conditions of this policy.
10
11 B. CalOptima shall establish a Shared Risk Pool each fiscal year (July 1 through June 30) during the
12 term of a Shared Risk Group's Contract for Health Care Services.
13
14 C. The Shared Risk Budget shall include:
15
16 1. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group
17 within the applicable period;
18
19 2. Monies recovered by CalOptima or a Provider from Coordination of Benefits for Shared Risk
20 Services provided to Members assigned to the Shared Risk Group, in accordance with
21 CalOptima Policy FF.2003: Coordination of Benefits;
22
23 3. Reinsurance recovery amounts as set forth in CalOptima Policy FF.1007: Health Network
24 Reinsurance Coverage; and
25
26 4. Supplemental OB Delivery Care payments as set forth in CalOptima Policy FF.1005f: Special
27 Payments: Supplemental OB Delivery Care Payment.
28
29 D. The Shared Risk Budget shall not include any amounts for Health Network Members eligible for the
30 California Children's Services (CCS) Program.
31
32 E. Shared Risk Expenses shall include:
33
34 1. Claims paid for Shared Risk Services provided to Members assigned to the Shared Risk Group;
35
36 2. An estimate of Incurred But Not Reported (IBNR) expenses for Shared Risk Services;
37
38 3. Administrative expenses at a rate established in the Contract for Health Care Services; and
39

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.

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 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:

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. 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;



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iii. 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. 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;

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

iv. 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.

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.

   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:

1 i. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk
2 Group within that fiscal year and up to the effective date of termination, including any
3 retroactivity within ninety (90) calendar days after the effective date of termination;
4
5 ii. Monies recovered by CalOptima or a Provider from Coordination of Benefits for dates
6 of service within that fiscal year and up to the effective date of termination, recovered
7 within ninety (90) calendar days after the effective date of termination;
8
9 iii. Reinsurance coverage amounts for dates of service within the fiscal year and up to the
10 effective date of termination, identified no later than ninety (90) calendar days after the
11 effective date of termination; and
12
13 iv. Supplemental OB Delivery Care payments for dates of service within that fiscal year
14 and up to the effective date of termination, identified within ninety (90) calendar days
15 after the effective date of termination.
16
17 b. CalOptima shall calculate Shared Risk Expenses for the reconciliation upon termination in
18 accordance with Sections II.E and II.F of this policy. Shared Risk Expenses for the
19 reconciliation upon termination shall include:
20
21 i. Claims for Shared Risk Services for dates of service within that fiscal year and up to the
22 effective date of termination, paid within ninety (90) calendar days following the
23 effective date of termination;
24
25 ii. An estimate of IBNR expenses for Shared Risk Services rendered within that fiscal year
26 and up to the effective date of termination, based on historical claims for Shared Risk
27 Services for dates of service within that fiscal year and paid up to ninety (90) calendar
28 days following the effective date of termination;
29
30 iii. Administrative expenses as established in the Contract for Health Care Services; and
31
32 iv. Any reinsurance premiums paid by CalOptima within that fiscal year and up to the
33 effective date of termination allocable to the Shared Risk Group.
34
35 c. Shared Risk Expenses shall not include:
36
37 i. Reimbursement for a High Cost Exclusion Item as set forth in CalOptima Policy
38 FF.1005.c: Special Payments – High Cost Exclusion Items.
39
40 d. CalOptima shall reduce Shared Risk Expenses for the fiscal year by:
41
42 i. Any applicable copayments, deductibles, or third-party payments collected by
43 CalOptima or a Provider for Shared Risk Services provided to Members assigned to the
44 Shared Risk Group during that fiscal year within ninety (90) calendar days after the
45 effective date of termination; and
46
47 ii. Any recoveries, including overpayments, for dates of service within that fiscal year and
48 up to the effective date of termination related to Shared Risk Services provided to
49 Members assigned to the Shared Risk Group and received within ninety (90) calendar
50 days after the effective date of termination.



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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.

   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. ATTACHMENTS

A. Risk Pool Claims Objection Form

## V. REFERENCES

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

1 **VI. REGULATORY AGENCY APPROVALS**
2
3 A. 03/14/11: Department of Health Care Services
4
5 **VII. BOARD ACTIONS**
6
7 A. 09/06/18: Regular Meeting of the CalOptima Board of Directors
8
9 **VIII. REVIEW/REVISION HISTORY**
10

| Version | Date | Policy Number | Policy Title | Line(s) of Business |
|---|---|---|---|---|
| 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 | 09/06/2018 | FF.1010 | Shared Risk Pool | Medi-Cal |

11

1 **IX. GLOSSARY**
2

| 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. |
| California Children's Services (CCS) Eligible Condition | Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae. |
| 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. |
| 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. |

| 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:<br>Amounts paid for Shared Risk Services provided to Members assigned to the Shared Risk Group;<br>An estimate of Incurred But Not Reported (IBNR) expenses;<br>Administrative expenses at a rate established in the Contract for Health Care Services; and<br>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. |

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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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|---|---|
| Policy #: | FF.4000 |
| Title: | **Whole-Child Model – Financial Reimbursement for Capitated Health Networks** |
| Department: | Finance |
| Section: | Accounting |

CEO Approval: Michael Schrader _______

| | |
|---|---|
| Effective Date: | 01/01/19 |
| Last Review Date: | Not applicable |
| Last Revised Date: | Not applicable |

## I. PURPOSE

This policy establishes the reimbursement process for CalOptima to distribute Whole-Child Model (WCM) payments timely and accurately to Health Networks, including Health Maintenance Organizations (HMO), Physician Hospital Consortiums (PHC), and Shared Risk Groups (SRG).

## II. POLICY

A. CalOptima shall pay the Health Network in accordance with the Health Network's Contract for Health Care Services, the CalOptima Board of Directors (BOD)-approved payment methodology, and the term and conditions of this policy.

B. CalOptima's WCM reimbursement methodology for Health Networks is based on the number of California Children's Services (CCS) Program-eligible Members, as reported by the California Department of Health Care Services (DHCS) and enrolled in Health Networks during the applicable period.

C. If DHCS identifies that an individual was not eligible for the CCS Program and retroactively terminates eligibility, CalOptima shall recover payments made to the Health Networks for such individual.

D. The measurement period for WCM payments is established by calendar year (CY). CalOptima shall keep each measurement period open for three (3) consecutive calendar years (Year 1, Year 2, and Year 3) before the payment is considered closed (e.g., measurement period CY 2019 will be finalized on December 31, 2021).

E. CalOptima reimburses Health Networks for services rendered to enrolled CCS-eligible Members based on a methodology that includes the following components described in this Policy:

1. Initial Capitation Payments;

2. Interim catastrophic payment; and

3. Retrospective risk corridor settlements.

1
2 F. The WCM payment timelines are:
3
4 1. Initial Capitation Payment: CalOptima shall pay monthly on or before the fifteenth (15th)
5 calendar day of the month.
6
7 2. Interim catastrophic reimbursement: CalOptima shall pay quarterly based on the
8 refreshed data for each measurement period as follows:
9

| CCS Eligible and Claims Incurred for Dates of Service | Claims Payment Period | Risk Corridor Settlement (Payment/ Recoupment) Date |
|---|---|---|
| a. January 1 – March 31, Year 1 | Year 1 paid through March 31 | No later than June 15, Year 1 |
| b. January 1 – June 30, Year 1 | Year 1 paid through June 30 | No later than September 15, Year 1 |
| c. January 1 – September 30, Year 1 | Year 1 paid through September 30 | No later than December 15, Year 1 |
| d. January 1 – December 31, Year 1 | Year 1 paid through December 31 | No later than March 15, Year 2 |
| e. January 1 – December 31, Year 1 | Year 1 paid through March 31, Year 2 | No later than June 15, Year 2 |

10
11 3. Retrospective risk corridor settlement: CalOptima shall pay annually based on the
12 refreshed data for each measurement period as follows:
13

| CCS Eligible and Claims Incurred for Dates of Service | Claims Payment Period | Risk Corridor Settlement (Payment/ Recoupment) Date |
|---|---|---|
| a. January 1 – December 31, Year 1 | Year 1 paid through June 30, Year 2 | No later than November 15, Year 2 |
| b. January 1 – December 31, Year 1 | Year 1 paid through June 30, Year 3 | No later than November 15, Year 3 |
| c. January 1 – December 31, Year 1 | Year 1 paid through June 30, Year 4 | No later than November 15, Year 4 |

14
15 **III. PROCEDURE**
16
17 A. Initial Capitation Payment
18
19 1. CalOptima shall provide monthly capitation payments for CCS-eligible Members
20 enrolled to the Health Networks at Capitation Rates per Member per month (PMPM)
21 developed by CalOptima, approved by the BOD and set forth in the Health Network's
22 Contract for Health Care Services.
23
24 2. CalOptima shall process the initial Capitation Payment in accordance with CalOptima
25 Policy FF.1001: Capitation Payments. CalOptima shall issue one (1) payment that



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includes the initial Capitation Payment for CCS-eligible Members combined with the Capitation Payment for non-CCS eligible Members.

B. Interim Catastrophic Reimbursement

1. Health Networks shall submit claims paid for covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members monthly by the fifteenth (15th) calendar day after the month ends for all open measurement periods. Health Networks shall submit claims using CalOptima proprietary format and file naming convention.

   a. An HMO shall submit claims for covered hospital and covered physician expenses;

   b. The Primary Physician Group of a PHC shall submit claims for covered physician expenses;

   c. The Primary Hospital of a PHC shall submit claims for covered hospital expenses; and

   d. An SRG shall submit claims for covered physician expenses.

2. CalOptima shall validate and reprice the submitted claims based on the CalOptima contracted and non-contracted rates following the lesser of the amount paid for covered physician and hospital expenses. Repricing will be made at fifty percent (50%) of the amount paid if Medi-Cal has no value for the five-digit numerical Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, or other code as assigned by DHCS. The qualified claims, as determined by CalOptima, shall represent the qualified WCM medical expenses used in the reconciliation process for the interim catastrophic reimbursement. Outlier claims may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

3. Upon request, an eligible Health Network shall provide, within ten (10) business days, detailed support for any individual claim for which billed charges are greater than or equal to ten thousand dollars ($10,000), including copies of the claim form, cancelled check, explanation of benefits (EOB), Remittance Advice Detail (RAD), and other information as requested by CalOptima. All non-contracted emergency hospital inpatient claims require submission of the authorization distinguishing days considered emergency and post-stabilization.

4. CalOptima shall notify an eligible Health Network of file acceptance or rejection within ten (10) business days after receipt.

   a. CalOptima may reject a file for any missing information or incorrect data.

   b. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days from receipt of notification from CalOptima.



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5. An eligible Health Network may appeal claim denials and payments within sixty (60) business days after the date of CalOptima's RAD.

   a. The eligible Health Network shall submit a request for appeal, in writing, to CalOptima at:

      WCMReimb@caloptima.org

      Or by U.S. mail to:

      Attention: Coding Initiatives Department—Reinsurance Claims
      CalOptima
      505 City Parkway West
      Orange, CA 92868

   b. An appeals claims submission file shall only include specific claims to be reconsidered.

   c. The eligible Health Network shall provide detailed claims support for each claim, including copies of the claim form, cancelled check, EOB, RAD, or any other information, as requested by CalOptima.

   d. CalOptima shall notify the eligible Health Network of file acceptance or rejection within ten (10) business days after receipt of the appeal file.

      i. CalOptima may reject a file for any missing information or incorrect data.

      ii. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days after receipt of notification from CalOptima.

   e. CalOptima shall process an appeal and provide an eligible Health Network with detailed reports within forty-five (45) business days after receipt of the appeal.

6. For each CCS eligible Member in a given measurement period, CalOptima shall reimburse at one hundred percent (100%) of the amount of the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members in excess of the thresholds which are:

   a. $17,000 for covered physician expenses; and

   b. $150,000 for covered hospital expenses.

7. CalOptima shall reconcile covered physician and covered hospital expenses separately. CalOptima shall issue interim catastrophic payments to Health Networks in accordance with the timelines in Section II.F.2 of this policy.

C. Retrospective Risk Corridor

   1. After the June claims submission, CalOptima shall perform an annual retrospective risk corridor reconciliation for all open measurement periods.



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2. CalOptima shall validate and reprice the submitted claims documents based on the lesser of the CalOptima contracted and non-contracted rates or the amount actually paid for covered physician and hospital expenses. Repricing will be made at fifty percent (50%) of the amount paid if Medi-Cal has no value for the five-digit numerical CPT code, HCPCS code, or other code as assigned by the DHCS. The qualified claims, as determined by CalOptima, shall represent the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members used in the retrospective risk corridor reconciliation. Similar to the interim catastrophic reimbursement, outlier claims may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

3. CalOptima shall perform the retrospective risk corridor reconciliation for physician Capitation and hospital Capitation separately.

   a. The baseline for the retrospective risk corridor reconciliation is an amount equal to the total Capitation Rate PMPM less the administrative and medical management loads PMPM developed by CalOptima, approved by the BOD, and set forth in the Health Network's Contract for Health Care Services, multiplied by the number of CCS eligible Members enrolled in the Health Networks during the applicable measurement period.

   b. The net difference between the baseline and the qualified WCM medical expenses from Section III.C.2 of this policy shall be applied to the risk corridor ranges approved by the BOD to determine an amount to be added or subtracted in the retrospective risk corridor reconciliation and referred to as risk corridor result in this policy.

| **Threshold** | **CalOptima's Risk/Surplus Share** |
|---|---|
| > 115% | 95% |
| 115% | 90% |
| 105% | 75% |
| 102% | 50% |
| 100% | 0% |
| 98% | 50% |
| 95% | 75% |
| 85% | 90% |
| < 85% | 100% |

   c. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A and III.B of this policy respectively for the applicable measurement period results in a positive amount, the retrospective risk corridor reconciliation computes the risk corridor payment.

d. If a total of baseline and risk corridor result subtracting initial Capitation Payments and interim catastrophic reimbursement from Sections III.A and III.B of this policy respectively for the applicable measurement period results in a negative amount, the retrospective risk corridor reconciliation computes the risk corridor recoupment.

e. Administrative and medical management components of CCS reimbursement will be adjusted based on the actual payout amount at previously established percentage.

4. No later than October 31, CalOptima shall provide the retrospective risk corridor reconciliation to the Health Networks. If, upon review of the retrospective risk corridor reconciliation, the Health Networks object to the calculations or medical expenses determination, the Health Networks may follow the dispute process outlined in section III.B.5. of this policy within thirty (30) calendar days from the issuance of the retrospective risk corridor reconciliation.

5. If CalOptima does not receive any written objection from the Health Networks, CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the expiration of the review period or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the expiration of the review period.

6. If CalOptima receives written objection from the Health Networks within the objection period, CalOptima shall review and provide responses to the Health Networks within forty-five (45) calendar days after the date of receipt of the written objection.

7. CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the date of issuance of the final retrospective risk corridor reconciliation or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the issuance of the final retrospective risk corridor reconciliation.

D. Medical expenses used in the reconciliation process for interim catastrophic reimbursement and retrospective risk corridor settlement shall be consistent with the financial risk in accordance with the Division of Financial Responsibility (DOFR) of the Health Network's Contract for Health Care Services.

## IV. ATTACHMENTS

Not Applicable

## V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy FF.1001: Capitation Payments

## VI. REGULATORY AGENCY APPROVALS

A. None to Date

## VII. BOARD ACTIONS



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1
2 A. TBD: Regular Meeting of the CalOptima Board of Directors
3
4
5 **VIII. REVIEW/REVISION HISTORY**
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| Version | Date | Policy Number | Policy Title | Line(s) of Business |
|---|---|---|---|---|
| Effective | 01/01/2019 | FF.4000 | Whole-Child Model – Financial Reimbursement for Capitated Health Networks | 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. |
| Capitation Rate | The per capita rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age, and gender. |
| Capitation Payment | The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender. |
| Contract for Health Care Services | The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Cared Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract. |
| 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. |
| Division of Financial Responsibility (DOFR) | A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange |
| Health Maintenance Organization (HMO) | A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code. |
| Health Network | A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members enrolled to that Health Network. |

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| Term | Definition |
|---|---|
| Member | A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program. |
| Measurement Period | Calendar year January 1 to December 31 |
| Open Measurement Period | The measurement year will remain open until the third annual report is issued to health network |
| Physician Hospital Consortium (PHC) | A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services. |
| Primary Hospital | A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC). |
| Primary Physician Group | A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC). |
| Shared Risk Group | A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services. |

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# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken August 2, 2018**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**

3. Consider Actions Related to CalOptima's Medi-Cal Whole-Child Model Program Provider Payment Methodology

**Contact**

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

**Recommended Actions**

Approve provider payment methodology for the CalOptima Medi-Cal Whole-Child Model (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 will implement the WCM program on a phased-in basis, with implementation for Orange County scheduled to begin no sooner than January 1, 2019. CalOptima will assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorization activities, claims management (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for Neonatal Intensive Care Unit (NICU) services. The Orange County Health Care Agency (OC HCA) will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members, including individuals who exceed the Medi-Cal income thresholds and undocumented children who transition out of CalOptima when they turn 18 years old. OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

In order to ensure compliance with regulatory requirements, CalOptima will refer to SB 586, guidance issued by DHCS through All Plan Letters (APL), plan contract amendments and readiness requirements, and CCS requirements published in the CCS Numbered Letters. Previously, CCS was carved-out of CalOptima's Medi-Cal MCP contract. As such, CalOptima CCS services were not included in the existing delivery model or health network contracts. CalOptima members receiving

CCS services were enrolled with CalOptima Direct (COD), CalOptima's Community Network (CCN), or other contracted health networks.

To meet the goals of the WCM, beginning January 1, 2019, CalOptima plans to allow members receiving CCS services to remain enrolled with either CalOptima's Community Network or other contracted CalOptima health networks. CalOptima will delegate CCS services to health networks according to the current health network models. The three health network models include Health Maintenance Organization (HMO), Physician-Hospital Consortium (PHC), or Shared-Risk Group (SRG).

## Discussion

DHCS Capitation Rates

CalOptima received draft Fiscal Year (FY) 2018-19 (effective January 2019 – June 2019) capitation rates from DHCS on April 27, 2018. The rates reflect reimbursement for both CCS and non-CCS services. CalOptima will continue to monitor the sufficiency of the WCM rates, and work closely with DHCS to ensure adequate Medi-Cal revenue to support the new program.

Projected Medical Costs

Staff has analyzed high-level data on the transitioning CCS-eligible group provided by the State. Generally, the transitioning group appears to incur extensive medical costs that are highly variable and volatile. In addition, the WCM population is relatively small, which reduces the ability to spread high cost cases across a larger enrollment. CalOptima has limited experience data available to forecast medical expenses and to make definitive assessments of potential financial risks.

Provider Payment Model

In order to mitigate potential financial risks to the health networks resulting from the implementation of the WCM program, CalOptima recommends creating a new provider reimbursement methodology specific to the WCM population, as summarized below. The goal of the new reimbursement methodology is to reduce the likelihood of unreasonable financial burdens on health networks due to potentially high costs for the WCM population. The following sections describe CalOptima's proposed WCM provider reimbursement by network arrangement type.

CalOptima Direct Networks (COD/CCN)

For direct fee-for-service providers, reimbursement will depend on whether the providers are contracted with CalOptima and whether they are paneled to provide CCS services.

For non-professional services, including hospital and ancillary, CalOptima will pay contracted providers at the contracted rate for both CCS and non-CCS members. CalOptima will reimburse non-contracted providers at 100% of the designated Medi-Cal payment rates.

For professional specialist services, CalOptima will continue to reimburse providers under the current CCS payment policy. Providers who are CCS paneled, whether they are contracted or non-contracted, will be reimbursed at 140% of the Medi-Cal Fee Schedule for all services provided to members under 21.

| Service Type | Contracted Provider | Non-Contracted Provider |
|---|---|---|
| Hospital & Ancillary | Contracted Rates | 100% of CalOptima Medi-Cal Fee Schedule |
| PCP | Contracted Rates | 100% of CalOptima Medi-Cal Fee Schedule |
| CCS Paneled Specialist | 140% of CalOptima Medi-Cal Fee Schedule | 140% of CalOptima Medi-Cal Fee Schedule |
| Non-CCS Paneled Specialist | Contracted Rates | 100% of CalOptima Medi-Cal Fee Schedule |

Delegated Health Networks (HMO/PHC/SRG)
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. To develop the initial capitation rate, CalOptima will employ the following methods:

- Establish estimated professional and hospital capitation rates that are consistent with DHCS' pricing methodology and include payments for CCS and non-CCS services;
- Align the service category pricing as closely as possible to the contracted division of financial responsibility associated with each health network and hospital;
- Carve out financial risk from the capitation rate for prescription drugs, managed long-term services and supports, and high cost conditions, including but not limited to members diagnosed with hemophilia, members in treatment for end stage renal disease (ESRD), members receiving an organ transplant, and maintenance and transportation costs for specific cases requiring special arrangements;
- Exclude projected expenses from the capitation rate for catastrophic cases. CalOptima will reimburse expenses to delegated health networks and hospitals through an interim catastrophic reimbursement process and risk corridor settlement;
- Apply blended capitation rates developed across all members and that are not separated into different age/gender bands. However, CalOptima will apply an age/gender factor by health network to adjust for cost variances due to the enrollment mix;
- Apply acuity risk factors to adjust for cost variances due to medical acuity; and
- Include an administration load to the both the professional and hospital capitation rates to address administrative expenses and medical management. The proposed 6.6% administration load is consistent the amount DHCS applies to CalOptima's WCM capitation rate. As proposed, CalOptima will keep this percentage fixed to ensure that health networks and hospitals are adequately compensated for the expenditures required to implement and manage the WCM program.

CalOptima 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, CalOptima will implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases and (2) Retrospective risk corridor.

1) Interim Reimbursement for Catastrophic Cases: The purpose of providing interim catastrophic reimbursement payments is to mitigate potential cash flow shortfalls due to the occurrence of high cost cases. CalOptima proposes implementing the following process to reimburse delegated health networks and hospitals for catastrophic cases to supplement their monthly capitation payments:

    - Reimbursement will be determined by the total delegated medical costs incurred for a given member within a given reconciliation period. If the total delegated medical costs for a given member exceed a prescribed threshold, CalOptima will reimburse the provider for the costs in excess of the threshold;
    - CalOptima will evaluate professional expenses and hospital expenses for a given member separately and will apply CalOptima's existing reinsurance thresholds of $17,000 per member per year for professional expenses and $150,000 per member per year for hospital expenses. CalOptima will not apply a coinsurance level to members in the WCM program;
    - Networks will be required to submit complete and accurate payment data to substantiate all incurred expenses. Payment data will be validated and repriced, similar to CalOptima's existing reinsurance reimbursement process; and
    - Initially, CalOptima will process the interim catastrophic reimbursement on a quarterly basis to minimize cash flow issues for health networks and hospitals. However, CalOptima may adjust the frequency of the reimbursement process in the event a health network or hospital requires reimbursement on a more timely basis.

2) Retrospective Risk Corridor: CalOptima will implement a retrospective risk corridor to better align health network and hospital capitation to their incurred costs. Risk corridors can serve as a safety net for providers that incur a high level of expenses relative to the capitation that they receive. CalOptima will work with health networks and hospitals to construct risk corridor parameters that provide adequate compensation, while still maintaining a reasonable financial incentive to efficiently manage utilization and costs. The risk corridor will be based on the following parameters:

    - Risk corridors will only apply to the medical component (excludes medical management and administration expenses) of the WCM capitation rate;
    - The prospective capitation rate will be used as the basis for the risk corridor reconciliation. CalOptima will also account for funding previously paid through the interim catastrophic reimbursement payment process during the reconciliation process;
    - The number of risk corridors applied and the range of each will be determined from an evaluation of projected risk to the delegated health networks and hospitals. Risk corridors will be set at levels that were projected to achieve an optimal balance that provides sufficient risk mitigation and financial incentives for providers;
    - Each risk corridor will have an associated percentage that splits risk between CalOptima and the provider. Similarly, risk sharing will be set at levels that achieve an optimal balance that provides sufficient risk mitigation and financial incentives for providers. The following table gives the proposed risk corridor ranges and risk sharing percentages:

| Medical Loss Ratio Threshold | CalOptima's Risk/Surplus Share | Description |
|---|---|---|
| > 115% | 95% | CalOptima will reimburse 95% of incurred medical expenses that are >115% |
| >105% to ≤ 115% | 90% | CalOptima will reimburse 90% of incurred medical expenses that are >105% and ≤ 115% |
| >102% to ≤ 105% | 75% | CalOptima will reimburse 75% of incurred medical expenses that are >102% and ≤ 105% |
| >100% to ≤ 102% | 50% | CalOptima will reimburse 50% of incurred medical expenses that are >100% and ≤ 102% |
| 100% | 0% | No change in reimbursement |
| < 100% to ≥ 98% | 50% | CalOptima will recoup 50% of capitation if medical expenses are <100% and ≥ 98% |
| < 98% to ≥ 95% | 75% | CalOptima will recoup 75% of capitation if medical expenses are <98% and ≥ 95% |
| < 95% to ≥ 85% | 90% | CalOptima will recoup 90% of capitation if medical expenses are <95% and ≥ 85% |
| < 85% | 100% | CalOptima will recoup 100% of capitation if medical expenses are <85% |

* Risk corridor will be evaluated from the medical component of the capitation rate.

- For SRG and PHC networks, risk corridor reconciliations will be evaluated separately for each capitation type (e.g. professional capitation and hospital capitation). For HMO health networks, risk corridor reconciliations will be evaluated against total capitation, which may include professional, hospital, pharmacy, or other delegated services, if applicable; and
- Risk corridor reconciliations will be performed on a calendar year basis, beginning with the period from January 1, 2019, to December 31, 2019. CalOptima may adjust the frequency as more experience becomes available. Each annual reconciliation report shall include refreshed reports from the previous two (2) annual settlement periods. After two (2) years, the refreshed report shall be considered final.

**Fiscal Impact**

Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. 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. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Considering the limited data available on the CCS population, the volatility associated with the cost of providing their care, and the protections being proposed for the health networks, the underlying

assumption behind the staff recommendation is that the state will ensure that the program is adequately funded. If this assumption were to prove inaccurate, the program could potentially represent significant economic downside to CalOptima.

**Rationale for Recommendation**
The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of CCS to the WCM, and to mitigate financial risks to our delegated health networks and hospitals.

**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**
None

*/s/ Michael Schrader* *7/25/2018*
**Authorized Signature** **Date**

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JENNIFER KENT
*DIRECTOR*

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
*GOVERNOR*

**DATE:** June 7, 2018

ALL PLAN LETTER 18-011

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

**SUBJECT:** CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

**PURPOSE:**
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program.

**BACKGROUND:**
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

MCPs will authorize care that is consistent with CCS Program standards and provided by CCS-paneled providers, approved special care centers, and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as

[1] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=123850.
[4] See Welfare and Institutions Code (WIC) Section 14094.11, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

continuity of care (COC), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning no sooner than July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

| MCP | COHS Counties |
| --- | --- |
| **Phase 1 – No sooner than July 1, 2018** | |
| CenCal Health | San Luis Obispo, Santa Barbara |
| Central California Alliance for Health | Merced, Monterey, Santa Cruz |
| Health Plan of San Mateo | San Mateo |
| **Phase 2 – No sooner than January 1, 2019** | |
| CalOptima | Orange |
| Partnership Health Plan | Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo |

**POLICY:**
Starting no sooner than July 1, 2018, MCPs in designated counties shall assume full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS will each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS Program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS Program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS Program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS Program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

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redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS Program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage (OHC), with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP) and Pediatric Palliative Care Waiver (PPCW). WCM counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs. The MCP is responsible for care coordination of services that remain carved-out of the MCP's contractual responsibilities.

MCPs are required to use all current and applicable CCS Program guidelines, including CCS Program regulations, additional forthcoming regulations related to the WCM program, CCS Numbered Letters (N.L.s),[6] and county CCS program information notices, in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations and contractual requirements.

## I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures, and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

### A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP will serve as the primary vehicle for ensuring

[6] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[7] A link to the MOU template can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP, consistent with the requirements of SB 586 and dependent upon DHCS approval. The MOU must include, at a minimum, all of the provisions specified in the MOU template. Phase 1 MCPs must have submitted an executed MOU, or proved intent and/or progress made towards an executed MOU, by March 31, 2018. Phase 2 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

**B. Transition Plan**

Each MCP must develop a comprehensive plan detailing the transition of existing CCS beneficiaries into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization administrative functions from the county CCS program to the MCPs.[8] The transition plan must also include communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

**C. Inter-County Transfer**

County CCS programs use CMSNet to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for COC of already approved service authorization requests, as required by this APL and applicable state and federal laws.

When a CCS-eligible member moves from a WCM county to a non-WCM county, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data

[8] See WIC Section 14094.7(d)(4)(C), which is available at:
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14094.7.

for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP as applicable.

**D. Dispute Resolution and Provider Grievances**

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[9] The county CCS program shall communicate all resolved disputes in writing to the MCP within a timely manner. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to CCSWCM@dhcs.ca.gov, for review and final determination.[10]

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[11] A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

## II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

**A. Risk Level and Needs Assessment Process**

The MCP will assess each CCS child's or youth's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL shall remove or limit existing survey or assessment requirements that the MCPs are responsible for outside WCM.

[9] See WIC Section 14093.06(b), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14093.06.
[10] Unresolved disputes must be referred to: CCSWCM@dhcs.ca.gov
[11] See WIC Section 14094.15(d), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14094.15.

1. **Pediatric Risk Stratification Process**
   MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new members, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level by:

   - Review of medical utilization and claims processing data, including data received from the county and DHCS;
   - Utilization of existing member assessment or survey data; and
   - Telephonic or in-person communications, if available at time of PRSP.

   Members that do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
   MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS paneled provider; this will be dependent upon the member's designation as high or low risk.

   *New Members and Newly CCS-eligible Members Determined High Risk*
   Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

   *Risk Assessment*
   The risk assessment process must address:

   a) General Health Status and Recent Health Care Utilization. This may include, but is not limited to, caretaker self-report of child's health;

outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time.

b) Health History. This includes both CCS and non-CCS diagnoses and past surgeries.

c) Specialty Provider Referral Needs.

d) Prescription Medication Utilization.

e) Specialized or Customized Durable Medical Equipment (DME) Needs (if applicable).

f) Need for Specialized Therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies (PT/OT /ST), mental or behavioral health services, and educational or developmental services.

g) Limitations of Activities of Daily Living or Daily Functioning (if applicable).

h) Demographics and Social History. This may include, but is not limited to, member demographics, assessment of home and school environments, and cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to assess the need for or impact of future health care services. These may include, but are not limited to, questions related to childhood developmental milestones; pediatric depression, anxiety or attention deficit screening; adolescent substance use; or adolescent sexual behaviors.

*Individual Care Plan*
MCPs are required to establish an ICP for all members determined high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
- County substance use disorder (SUD) or Drug Medi-Cal services;

[12] See WIC Section 14094.11(b)(4), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

The ICP will be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or their designated caregiver. The ICP should indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP should also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

a) Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an interdisciplinary team is, and what the community resources are.

b) A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions.

c) Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams.

d) Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess the member's risk level and needs annually at their CCS eligibility redetermination or upon significant change to the member's condition.

[13] See WIC Section 14094.11(c), which is available at:
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

*New Members and Newly CCS-eligible Members Determined Low Risk*
For new members and newly CCS-eligible members identified as lower risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of their enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination or upon significant change to the member's condition.

*WCM Transitioning Members*
For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination, or upon significant change to the member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless of the risk level of a member, all communications, whether by phone or mail, must inform the member and/or his or her designated caregiver that the assessment will be provided in a linguistically and culturally appropriate manner and identify the method by which the provider will arrange for an in-person assessment.[14]

MCPs must refer all members, including new members, newly CCS-eligible members and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and not wait until the annual CCS medical eligibility redetermination period.

**B. Case Management and Care Coordination**
MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs must ensure that information, education and support is continuously provided to the CCS-eligible member and their family to

[14] See APL 99-005, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL1999/MMCDAPL99005.pdf

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assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:[15]

- Primary and preventive care services with specialty care services
- Medical therapy units (MTU)
- EPSDT[16]
- Regional center services
- Home and community-based services

**1. High Risk Infant Follow-Up Program**
High Risk Infant Follow-Up (HRIF) is a program that helps identify infants who might develop CCS-eligible conditions after they are discharged from a Neonatal Intensive Care Unit (NICU). The MCP is responsible for coordinating and authorizing HRIF services for members and ensuring HRIF case management services. MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide COC information to the members.

**2. Age-Out Planning Responsibility**
MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the members' CCS qualifying condition(s).

MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[17]

**3. Pediatric Provider Phase-Out Plan**
A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the child or youth. The MCPs must provide care coordination to

[15] See WIC Section14094.11(b)(1)-(6), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14094.11.
[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See APL 18-007, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-007.pdf
[17] See WIC Section 14094.12(j), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14094.12.

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CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

**C. Continuity of Care**

MCPs must establish and maintain a process to allow for members to receive COC with existing CCS provider(s) for up to 12 months, in accordance with WIC Section 14094.13.[18] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all other applicable APLs regarding COC. The sections below include additional COC requirements that only pertain to the WCM program.

**1. Specialized or Customized Durable Medical Equipment**

If the MCP member has an established relationship with a specialized or customized durable medical equipment (DME) provider, MCPs must provide access to that provider for up to 12 months.[19] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service rates, unless the DME provider and the MCP enter into an agreement on an alternative payment methodology that is mutually agreed upon. The MCP may extend the COC period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[20]

Specialized or Customized DME must meet all of the following criteria:

- Is uniquely constructed or substantially modified solely for the use of the member.
- Is made to order or adapted to meet the specific needs of the member.
- Is uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

**2. COC Case Management**[21]

MCPs must ensure CCS-eligible members receive expert case management,

[18] See WIC Section 14094.13, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14094.13.
[19] See WIC Section 14094.12(f), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.12.&lawCode=WIC
[20] See WIC Section 14094.13(b)(3) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[21] See WIC Section 14094.13(e), (f) and (g), which are available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing the CCS-eligible member, member's family, or designated caregiver to request COC case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with a MCP case manager who has received adequate training on the county CCS Program and who has clinical experience with the CCS population or pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services The MCP must send a follow-up notice 30 days prior to the start of the transition.

3. **Authorized Prescription Drugs**
CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[22]

4. **Appealing COC Limitations**
MCPs must provide CCS-eligible members with information regarding the WCM appeal process for COC limitations, in writing, 60 days prior to the end of their authorized COC period. The notice must explain the member's right to petition the MCP for an extension of the COC period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition.[23] The appeals process notice must include the following information:

- The CCS-eligible member must first appeal a COC decision with the MCP.
- A CCS-eligible member, member's family or designated caregiver of the CCS-eligible member may appeal the COC limitation to the DHCS director or his or her designee after exhausting the MCP's appeal process.

[22] See WIC Section 14094.13(d)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[23] See WIC Section 14094.13(k), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

- The DHCS director or designee will have five (5) days from the date of appeal to inform the family or caregiver of receipt of the request and must provide a decision on the appeal within 30 calendar days from the date of the request. If the member's health is at risk, the DHCS director or designee will inform the member of the decision within 72 hours.[24]

In addition to the protections set forth above, MCP members also have COC rights under current state law.

**D. Grievance, Appeal, and State Fair Hearing Process**

MCPs must ensure members are provided information on grievances, appeals and state fair hearing processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal and state fair hearing rights as provided under state and federal law.[25] MCPs must provide timely processes for accepting and acting upon member complaints and grievances. Members appealing a CCS eligibility determination must appeal to the county CCS program.

**E. Transportation**

MCPs must provide the CCS Maintenance and Transportation (M&T) benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.), in addition to transportation expenses, and must comply with all requirements listed in N.L. 03-0810.[26] These services include, but are not limited to, M&T for out of county and out of state services.

MCPs must also comply with all requirements listed in APL 17-010[27] for CCS-eligible members to obtain non-emergency medical transportation (NEMT) and non-medical transportation (NMT) for all other services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.

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[24] See APL 17-006, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf
[25] See APL 17-006
[26] See CCS N.L. 03-0810, which is available at:
http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl030810.pdf
[27] APL 17-010 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf

**F. Out-of-Network Access**

MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services.

**G. Advisory Committees**

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.[28] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[29] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[30]

## III. WCM Payment Structure

**A. Payment and Fee Rate**

MCPs are required to pay providers at rates that are at least equal to the applicable CCS fee-for-service rates, unless the provider and the MCP enter into

[28] See WIC Section 14094.7(d)(3), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.7.&lawCode=WIC
[29] See WIC Section 14094.17(b)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC
[30] See WIC Section 14094.17(a), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC

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an agreement on an alternative payment methodology that is mutually agreed upon.[31]

The payor for NICU services is as follows: an MCP shall pay for NICU services in counties where NICU is carved into the MCP's rate, and DHCS shall pay in counties where NICU is carved out of the MCP's rate.[32]

For WCM counties, all NICU authorizations will be sent to the MCP in which the child is enrolled. The MCP will review authorizations and determine whether or not the services meet CCS NICU requirements. However, claims may be processed and paid by either DHCS or the MCP.

In counties where CCS NICU is carved into the MCP's rate, the MCP will pay all NICU and CCS NICU claims. For counties where CCS is currently carved-out, the MCP will process and pay non-CCS NICU claims, and the State's Fiscal Intermediary will pay CCS NICU claims. Payments made by State's Fiscal Intermediary will be based on the MCP's approval of meeting CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

| CCS NICU | NICU Acuity Assessment | Authorization | Payor (Facility/ Physician) |
|---|---|---|---|
| **Carved-In Counties:** Marin, Merced, Monterey, Napa, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo | MCP | MCP | MCP |

[31] See WIC Section 14094.16(b), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14094.16.
[32] See the Division of Responsibility chart

| CCS NICU | NICU Acuity Assessment | Authorization | Payor (Facility/ Physician) |
|---|---|---|---|
| **Carved-Out:** Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Orange, Shasta, Siskiyou, Sonoma, and Trinity | MCP | MCP | DHCS |

## IV. MCP Responsibilities to DHCS

### A. Network Certification

MCPs are required to have an adequate network of providers to serve the CCS-eligible population including physicians, specialists, allied professionals, Special Care Centers, hospitals, home health agencies, and specialized and customizable DME providers. Each network of providers will be reviewed by DHCS and certified annually.

The certification requires the MCP and their delegated entities to submit updated policies and procedures and an updated provider network template to ensure the MCP's network of providers meets network adequacy requirements as described in the Network Certification APL Attachments.[33]

MCPs must demonstrate that the provider network contains an adequate provider overlap with CCS-paneled providers. MCPs must submit provider network documentation to DHCS, as described in APL 18-005. Members cannot be limited to a single delegated entity's provider network. The MCP must ensure members have access to all medically necessary CCS-paneled providers within the MCP's entire provider network. MCPs must submit policies and procedures to DHCS no later than 105 days before the start of the contract year.

### B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional

[33] APL 18-005 and its attachments are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

approval status.[34] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[35] The MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[36]

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. The MCP's written policies and procedures must follow the credentialing and recredentialing guidelines of APL 17-019.[37] MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

**C. Utilization Management**

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[38]

- Procedures for pre-authorization, concurrent review, and retrospective review.
- A list of services requiring prior authorization and the utilization review criteria.
- Procedures for the utilization review appeals process for providers and members.
- Procedures that specify timeframes for medical authorization.
- Procedures to detect both under- and over-utilization of health care services.

In addition to the UM processes above, MCPs are responsible for conducting NICU acuity assessments and authorizations in all WCM counties.[39]

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[34] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[35] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[36] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf
[37] APL 17-019 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf
[38] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[39] See WIC 14094.65, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC

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**D. MCP Reporting Requirements**

1. **Quality Performance Measures**
DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a form and manner specified by DHCS.

2. **Reporting and Monitoring**
DHCS will develop specific monitoring and oversight standards for MCPs. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companions guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required data in a form and manner specified by DHCS and must comply with all contractual requirements.

**E. Delegation of Authority**
In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in APL 17-004.[40] 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

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[40] APL 17-004 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-004.pdf

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JENNIFER KENT
*DIRECTOR*

State of California—Health and Human Services Agency
# Department of Health Care Services

EDMUND G. BROWN JR.
*GOVERNOR*

**DATE:** June 7, 2018

ALL PLAN LETTER 18-011

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

**SUBJECT:** CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

**PURPOSE:**
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program.

**BACKGROUND:**
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

MCPs will authorize care that is consistent with CCS Program standards and provided by CCS-paneled providers, approved special care centers, and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as

[1] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=123850.
[4] See Welfare and Institutions Code (WIC) Section 14094.11, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

continuity of care (COC), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning no sooner than July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

| MCP | COHS Counties |
|---|---|
| **Phase 1 – No sooner than July 1, 2018** | |
| CenCal Health | San Luis Obispo, Santa Barbara |
| Central California Alliance for Health | Merced, Monterey, Santa Cruz |
| Health Plan of San Mateo | San Mateo |
| **Phase 2 – No sooner than January 1, 2019** | |
| CalOptima | Orange |
| Partnership Health Plan | Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo |

**POLICY:**
Starting no sooner than July 1, 2018, MCPs in designated counties shall assume full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS will each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS Program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS Program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS Program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS Program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS Program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage (OHC), with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP) and Pediatric Palliative Care Waiver (PPCW). WCM counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs. The MCP is responsible for care coordination of services that remain carved-out of the MCP's contractual responsibilities.

MCPs are required to use all current and applicable CCS Program guidelines, including CCS Program regulations, additional forthcoming regulations related to the WCM program, CCS Numbered Letters (N.L.s),[6] and county CCS program information notices, in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations and contractual requirements.

## I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures, and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

### A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP will serve as the primary vehicle for ensuring

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[6] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[7] A link to the MOU template can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

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collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP, consistent with the requirements of SB 586 and dependent upon DHCS approval. The MOU must include, at a minimum, all of the provisions specified in the MOU template. Phase 1 MCPs must have submitted an executed MOU, or proved intent and/or progress made towards an executed MOU, by March 31, 2018. Phase 2 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

**B. Transition Plan**

Each MCP must develop a comprehensive plan detailing the transition of existing CCS beneficiaries into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization administrative functions from the county CCS program to the MCPs.[8] The transition plan must also include communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

**C. Inter-County Transfer**

County CCS programs use CMSNet to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for COC of already approved service authorization requests, as required by this APL and applicable state and federal laws.

When a CCS-eligible member moves from a WCM county to a non-WCM county, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data

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[8] See WIC Section 14094.7(d)(4)(C), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14094.7.

for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP as applicable.

**D. Dispute Resolution and Provider Grievances**

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[9] The county CCS program shall communicate all resolved disputes in writing to the MCP within a timely manner. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to CCSWCM@dhcs.ca.gov, for review and final determination.[10]

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[11] A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

## II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

**A. Risk Level and Needs Assessment Process**

The MCP will assess each CCS child's or youth's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL shall remove or limit existing survey or assessment requirements that the MCPs are responsible for outside WCM.

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[9] See WIC Section 14093.06(b), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14093.06.
[10] Unresolved disputes must be referred to: CCSWCM@dhcs.ca.gov
[11] See WIC Section 14094.15(d), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14094.15.

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1. **Pediatric Risk Stratification Process**
   MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new members, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level by:

   - Review of medical utilization and claims processing data, including data received from the county and DHCS;
   - Utilization of existing member assessment or survey data; and
   - Telephonic or in-person communications, if available at time of PRSP.

   Members that do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
   MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS paneled provider; this will be dependent upon the member's designation as high or low risk.

   *New Members and Newly CCS-eligible Members Determined High Risk*
   Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

   *Risk Assessment*
   The risk assessment process must address:

   a) General Health Status and Recent Health Care Utilization. This may include, but is not limited to, caretaker self-report of child's health;

outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time.

b) Health History. This includes both CCS and non-CCS diagnoses and past surgeries.
c) Specialty Provider Referral Needs.
d) Prescription Medication Utilization.
e) Specialized or Customized Durable Medical Equipment (DME) Needs (if applicable).
f) Need for Specialized Therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies (PT/OT /ST), mental or behavioral health services, and educational or developmental services.
g) Limitations of Activities of Daily Living or Daily Functioning (if applicable).
h) Demographics and Social History. This may include, but is not limited to, member demographics, assessment of home and school environments, and cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to assess the need for or impact of future health care services. These may include, but are not limited to, questions related to childhood developmental milestones; pediatric depression, anxiety or attention deficit screening; adolescent substance use; or adolescent sexual behaviors.

*Individual Care Plan*
MCPs are required to establish an ICP for all members determined high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
- County substance use disorder (SUD) or Drug Medi-Cal services;

[12] See WIC Section 14094.11(b)(4), which is available at:
http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

The ICP will be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or their designated caregiver. The ICP should indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP should also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

a) Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an interdisciplinary team is, and what the community resources are.

b) A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions.

c) Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams.

d) Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess the member's risk level and needs annually at their CCS eligibility redetermination or upon significant change to the member's condition.

[13] See WIC Section 14094.11(c), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

*New Members and Newly CCS-eligible Members Determined Low Risk*
For new members and newly CCS-eligible members identified as lower risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of their enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination or upon significant change to the member's condition.

*WCM Transitioning Members*
For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination, or upon significant change to the member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless of the risk level of a member, all communications, whether by phone or mail, must inform the member and/or his or her designated caregiver that the assessment will be provided in a linguistically and culturally appropriate manner and identify the method by which the provider will arrange for an in-person assessment.[14]

MCPs must refer all members, including new members, newly CCS-eligible members and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and not wait until the annual CCS medical eligibility redetermination period.

**B. Case Management and Care Coordination**
MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs must ensure that information, education and support is continuously provided to the CCS-eligible member and their family to

[14] See APL 99-005, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL1999/MMCDAPL99005.pdf

assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:[15]

- Primary and preventive care services with specialty care services
- Medical therapy units (MTU)
- EPSDT[16]
- Regional center services
- Home and community-based services

**1. High Risk Infant Follow-Up Program**
High Risk Infant Follow-Up (HRIF) is a program that helps identify infants who might develop CCS-eligible conditions after they are discharged from a Neonatal Intensive Care Unit (NICU). The MCP is responsible for coordinating and authorizing HRIF services for members and ensuring HRIF case management services. MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide COC information to the members.

**2. Age-Out Planning Responsibility**
MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the members' CCS qualifying condition(s).

MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[17]

**3. Pediatric Provider Phase-Out Plan**
A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the child or youth. The MCPs must provide care coordination to

[15] See WIC Section14094.11(b)(1)-(6), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14094.11.
[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See APL 18-007, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-007.pdf
[17] See WIC Section 14094.12(j), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14094.12.

CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

**C. Continuity of Care**

MCPs must establish and maintain a process to allow for members to receive COC with existing CCS provider(s) for up to 12 months, in accordance with WIC Section 14094.13.[18] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all other applicable APLs regarding COC. The sections below include additional COC requirements that only pertain to the WCM program.

**1. Specialized or Customized Durable Medical Equipment**

If the MCP member has an established relationship with a specialized or customized durable medical equipment (DME) provider, MCPs must provide access to that provider for up to 12 months.[19] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service rates, unless the DME provider and the MCP enter into an agreement on an alternative payment methodology that is mutually agreed upon. The MCP may extend the COC period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[20]

Specialized or Customized DME must meet all of the following criteria:

- Is uniquely constructed or substantially modified solely for the use of the member.
- Is made to order or adapted to meet the specific needs of the member.
- Is uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

**2. COC Case Management**[21]

MCPs must ensure CCS-eligible members receive expert case management,

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[18] See WIC Section 14094.13, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14094.13.
[19] See WIC Section 14094.12(f), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.12.&lawCode=WIC
[20] See WIC Section 14094.13(b)(3) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[21] See WIC Section 14094.13(e), (f) and (g), which are available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing the CCS-eligible member, member's family, or designated caregiver to request COC case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with a MCP case manager who has received adequate training on the county CCS Program and who has clinical experience with the CCS population or pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services The MCP must send a follow-up notice 30 days prior to the start of the transition.

3. **Authorized Prescription Drugs**
CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[22]

4. **Appealing COC Limitations**
MCPs must provide CCS-eligible members with information regarding the WCM appeal process for COC limitations, in writing, 60 days prior to the end of their authorized COC period. The notice must explain the member's right to petition the MCP for an extension of the COC period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition.[23] The appeals process notice must include the following information:

- The CCS-eligible member must first appeal a COC decision with the MCP.
- A CCS-eligible member, member's family or designated caregiver of the CCS-eligible member may appeal the COC limitation to the DHCS director or his or her designee after exhausting the MCP's appeal process.

[22] See WIC Section 14094.13(d)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[23] See WIC Section 14094.13(k), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

- The DHCS director or designee will have five (5) days from the date of appeal to inform the family or caregiver of receipt of the request and must provide a decision on the appeal within 30 calendar days from the date of the request. If the member's health is at risk, the DHCS director or designee will inform the member of the decision within 72 hours.[24]

In addition to the protections set forth above, MCP members also have COC rights under current state law.

**D. Grievance, Appeal, and State Fair Hearing Process**

MCPs must ensure members are provided information on grievances, appeals and state fair hearing processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal and state fair hearing rights as provided under state and federal law.[25] MCPs must provide timely processes for accepting and acting upon member complaints and grievances. Members appealing a CCS eligibility determination must appeal to the county CCS program.

**E. Transportation**

MCPs must provide the CCS Maintenance and Transportation (M&T) benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.), in addition to transportation expenses, and must comply with all requirements listed in N.L. 03-0810.[26] These services include, but are not limited to, M&T for out of county and out of state services.

MCPs must also comply with all requirements listed in APL 17-010[27] for CCS-eligible members to obtain non-emergency medical transportation (NEMT) and non-medical transportation (NMT) for all other services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.

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[24] See APL 17-006, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf
[25] See APL 17-006
[26] See CCS N.L. 03-0810, which is available at:
http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl030810.pdf
[27] APL 17-010 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf

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**F. Out-of-Network Access**

MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services.

**G. Advisory Committees**

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.[28] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[29] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[30]

## III. WCM Payment Structure

**A. Payment and Fee Rate**

MCPs are required to pay providers at rates that are at least equal to the applicable CCS fee-for-service rates, unless the provider and the MCP enter into

[28] See WIC Section 14094.7(d)(3), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.7.&lawCode=WIC
[29] See WIC Section 14094.17(b)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC
[30] See WIC Section 14094.17(a), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC

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an agreement on an alternative payment methodology that is mutually agreed upon.[31]

The payor for NICU services is as follows: an MCP shall pay for NICU services in counties where NICU is carved into the MCP's rate, and DHCS shall pay in counties where NICU is carved out of the MCP's rate.[32]

For WCM counties, all NICU authorizations will be sent to the MCP in which the child is enrolled. The MCP will review authorizations and determine whether or not the services meet CCS NICU requirements. However, claims may be processed and paid by either DHCS or the MCP.

In counties where CCS NICU is carved into the MCP's rate, the MCP will pay all NICU and CCS NICU claims. For counties where CCS is currently carved-out, the MCP will process and pay non-CCS NICU claims, and the State's Fiscal Intermediary will pay CCS NICU claims. Payments made by State's Fiscal Intermediary will be based on the MCP's approval of meeting CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

| CCS NICU | NICU Acuity Assessment | Authorization | Payor (Facility/ Physician) |
|---|---|---|---|
| **Carved-In Counties:** Marin, Merced, Monterey, Napa, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo | MCP | MCP | MCP |

[31] See WIC Section 14094.16(b), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14094.16.
[32] See the Division of Responsibility chart

| CCS NICU | NICU Acuity Assessment | Authorization | Payor (Facility/ Physician) |
|---|---|---|---|
| **Carved-Out:** Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Orange, Shasta, Siskiyou, Sonoma, and Trinity | MCP | MCP | DHCS |

## IV. MCP Responsibilities to DHCS

### A. Network Certification

MCPs are required to have an adequate network of providers to serve the CCS-eligible population including physicians, specialists, allied professionals, Special Care Centers, hospitals, home health agencies, and specialized and customizable DME providers. Each network of providers will be reviewed by DHCS and certified annually.

The certification requires the MCP and their delegated entities to submit updated policies and procedures and an updated provider network template to ensure the MCP's network of providers meets network adequacy requirements as described in the Network Certification APL Attachments.[33]

MCPs must demonstrate that the provider network contains an adequate provider overlap with CCS-paneled providers. MCPs must submit provider network documentation to DHCS, as described in APL 18-005. Members cannot be limited to a single delegated entity's provider network. The MCP must ensure members have access to all medically necessary CCS-paneled providers within the MCP's entire provider network. MCPs must submit policies and procedures to DHCS no later than 105 days before the start of the contract year.

### B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional

[33] APL 18-005 and its attachments are available at:
http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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approval status.[34] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[35] The MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[36]

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. The MCP's written policies and procedures must follow the credentialing and recredentialing guidelines of APL 17-019.[37] MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

**C. Utilization Management**

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[38]

- Procedures for pre-authorization, concurrent review, and retrospective review.
- A list of services requiring prior authorization and the utilization review criteria.
- Procedures for the utilization review appeals process for providers and members.
- Procedures that specify timeframes for medical authorization.
- Procedures to detect both under- and over-utilization of health care services.

In addition to the UM processes above, MCPs are responsible for conducting NICU acuity assessments and authorizations in all WCM counties.[39]

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[34] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[35] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[36] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf
[37] APL 17-019 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf
[38] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[39] See WIC 14094.65, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC

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**D. MCP Reporting Requirements**

**1. Quality Performance Measures**
DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a form and manner specified by DHCS.

**2. Reporting and Monitoring**
DHCS will develop specific monitoring and oversight standards for MCPs. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companions guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required data in a form and manner specified by DHCS and must comply with all contractual requirements.

**E. Delegation of Authority**
In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in APL 17-004.[40] 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

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[40] APL 17-004 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-004.pdf

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*Continued to a Future Meeting*

# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken September 5, 2019**
**Ad-Hoc Meeting of the CalOptima Board of Directors**

**Report Item**

6. Consider Authorizing Supplemental Payments to Health Networks for Specific Home Health Agency Services

**Contact**

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

**Recommended Actions**

1. Authorize the Chief Executive Officer (CEO) to make supplemental payments for specific home health agency services to health networks from July 1, 2018, through June 30, 2019;
2. Approve disbursement methodology for these supplemental payments;
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
4. Authorize the CEO to execute agreements and/or contract amendments as necessary for implementation.

**Background**

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) increased the excise tax rate on cigarettes and tobacco products to fund specified expenditures. Senate Bill (SB) 856 appropriated Proposition 56 funds in the 2018-19 state fiscal year (SFY) for defined DHCS supplemental payment expenditures.

On September 17, 2018, DHCS received federal approval for State Plan Amendment 18-0037 to sunset the one percent (1%) payment reduction for home health agency services and to increase reimbursement rates in effect on June 30, 2018, for state plan home health agency and certain Pediatric Day Health Care services by fifty percent (50%) effective July 1, 2018. The following procedure codes provide increased Medi-Cal reimbursement rates for certain home health agency services effective July 1, 2018. These procedure codes mainly apply to pediatric Medi-Cal members. As such, implementing the new rates will directly affect the Whole Child Model (WCM) population.

| Procedure Code | Medi-Cal Rate | | Procedure Code | Medi-Cal Rate |
|---|---|---|---|---|
| Z5804 | $47.91 | | Z5834 | $44.12 |
| Z5805 | $52.70 | | Z5835 | $48.53 |
| Z5806 | $36.63 | | Z5836 | $68.15 |
| Z5807 | $40.29 | | Z5838 | $28.35 |
| Z5832 | $60.86 | | Z5840 | $53.66 |
| Z5833 | $66.95 | | Z5868 | $44.12 |

DHCS noted that providers in the Medi-Cal fee-for-service (FFS) delivery systems and impacted Home and Community-based Services (HCBS) waivers will receive the rate increases.

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**Discussion**

Staff updated internal systems to reflect the increased rates for certain home health agency services on August 28, 2018. Providers contracted directly with CalOptima (i.e., CalOptima Direct, CalOptima Care Network) received a retroactive true-up payment (effective July 1, 2018) and began receiving updated rates in September 2018.

With no additional funding anticipated from DHCS, Staff assumes that costs and trends for the increased rates for home health agency services will be incorporated in a future Rate Development Template (RDT). In general, a unit cost change imposed by DHCS will not result in a supplemental payment beyond CalOptima's primary capitation to health networks. These cost changes are incorporated in CalOptima's regular rebasing exercise which are inclusive of forward trend assumptions.

However, given the 50% unit cost trend applied by DHCS and the corresponding negative fiscal impact to health networks, Management recommends the provision of a supplemental payment for the period of July 1, 2018, through June 30, 2019. Beginning July 1, 2019, with the implementation of the WCM program, the majority (approximately 80% to 85%) of home health agency services will be incorporated into the health networks' WCM all-inclusive capitation rate. As such, the end-date for the supplemental payment methodology is June 30, 2019.

Proposed Payment Methodology

Health Networks will submit encounter data evidencing the Health Networks' reimbursement of the home health agency services at the increased rates during the period of July 1, 2018, through June 30, 2019, to CalOptima. If a Health Network has made payments at the increased rate, CalOptima will reimburse the Health Network for the increased unit cost expense. CalOptima staff will evaluate the encounter data in October 2019 and perform a final reconciliation in April 2020 to confirm that Health Networks have made payments at the higher rates. CalOptima will incorporate the home health unit cost adjustment in the HMO/PHC hospital capitation benchmark for the shared risk pool calculation for Fiscal Year (FY) 2018-19.

**Fiscal Impact**

The annual delegated volume for certain home health agency services from July 1, 2018, through June 30, 2019, is approximately $4.3 million. The net fiscal impact to CalOptima, assuming a 50% unit cost trend, is approximately $2.15 million. Staff anticipates that the forecasted expense trend included in the Board-approved FY 2019-20 Medi-Cal Operating Budget is sufficient to cover the anticipated costs related to the recommended action, inclusive of the resulting increase to the shared risk pool payout.

**Rationale for Recommendation**

The recommended action will ensure that CalOptima's delegated entities are appropriately funded for home health agency services in order to pay providers at the increased rates.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

1. Entities Covered by this Board Action

*/s/ Michael Schrader* *8/28/19*
**Authorized Signature** **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

| **Health Network** | **Address** | **City** | **State** | **Zip Code** |
|---|---|---|---|---|
| AltaMed Health Services Corporation | 2040 Camfield Ave. | Los Angeles | CA | 90040 |
| ARTA Western California Inc. | 3390 Harbor Blvd | Costa Mesa | CA | 92626 |
| Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County | 5785 Corporate Ave | Cypress | CA | 90630 |
| Talbert Medical Group, PC. | 3390 Harbor Blvd | Costa Mesa | CA | 92626 |
| United Care Medical Group | 600 City Parkway West, #400 | Orange | CA | 92868 |
| AMVI Care Health Network | 600 City Parkway West, #800 | Orange | CA | 92868 |
| Family Choice Medical Group, Inc. | 15821 Ventura Blvd.m #600 | Encino | CA | 91436 |
| Fountain Valley Regional Hospital and Medical Center | 1400 South Douglass, Suite 250 | Anaheim | CA | 92860 |
| CHOC Physicians Network + Children's Hospital of Orange County | 1120 West La Veta Ave, Suite 450 | Orange | CA | 92868 |
| Heritage Provider Network, Inc. | 8510 Balboa Blvd, Suite 150 | Northridge | CA | 91325 |
| Monarch Health Plan, Inc. | 11 Technology Dr. | Irvine | CA | 92618 |
| Prospect Health Plan, Inc. | 600 City Parkway West, #800 | Orange | CA | 92868 |
| Kaiser Foundation Health Plan, Inc. | 393 Walnut St | Pasadena | CA | 91188 |

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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**

7. 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 (PACE)

**Contact**

David Ramirez, Chief Medical Officer, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

**Recommended Action**

Authorize and direct the Chairman of the Board of Directors to execute Amendment A08 to the PACE Agreement between the Department of Health Care Services and CalOptima regarding Calendar Year 2019 capitation rates and other changes to contractual requirements.

**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 the Department of Health Care Services (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 Calendar Year (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 Agreement expires on December 31, 2019, with capitation rates renewed on a calendar year basis.

**Discussion**

On August 8, 2019, DHCS provided CalOptima with Amendment A08 for the DHCS PACE Agreement to include updates for:

- Implementing the CY 2019 capitation rates retroactive to January 1, 2019;
- Updating language in Exhibit A regarding Nursing Facility Services payment rates;
- Increasing the maximum amount payable to accommodate for the continuation of services; and
- All other terms and conditions in the CalOptima DHCS PACE Agreement remaining the same.

***Rate Revisions – Calendar Year 2019 Rate Amendment (Exhibit B)***

On December 31, 2018, DHCS provided CalOptima with the draft proposed rates for CY 2019, for the period of January 1, 2019 through December 31, 2019. The methodology used to develop

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them 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 finalized the CY 2019 rates and worked with CMS between the December 2018 and July 2019 for approval. DHCS's final CY 2019 rate amendment is consistent with the draft version provided to CalOptima and will be retroactive to the beginning of 2019.

Rate changes for the period January 1, 2019 through December 31, 2019 reflect the following:

- Revised capitation rates, retroactive to January 1, 2019.
- The Managed Care Organization (MCO) tax will apply to capitation for both the *Full-Dual* population and *Non-Dual eligible* population.
- The revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population have built-in adjustments for Medi-Cal program changes.

***Language Changes: Updates to Nursing Facility Service Payment Terms (Exhibits A)***
This amendment also incorporates additional language updates for the following provisions:

1. Exhibit B, Attachment 10 - Scope of Services, Provision 5B. Nursing Facility Services
   - Amended language regarding Nursing Facility Services payment rates, to specify that "Contractor shall reimburse contracted providers at rates that are not less than Medi-Cal Fee-For-Services (FFS) rates, as published and revised by DHCS, including retroactive payment of any additional rate increment based on DHCS retroactive rate adjustments, for equivalent services for the date(s) of service."

2. All other terms and conditions in the CalOptima DHCS PACE Agreement remain unchanged.

**Fiscal Impact**
The recommended action to execute Amendment A08 to the DHCS PACE Agreement will implement final CY 2019 Medi-Cal PACE rates. Upon analysis, Staff estimates the retroactive application of the revised capitation rates and actual PACE enrollment for the period of January 1, 2019, through December 31, 2019, results in a net increase in revenue of approximately $28,000 as compared to draft CY 2019 Medi-Cal PACE rates which were previously used for accruals.

**Rationale for Recommendation**
CalOptima's execution of Amendment A08 to the DHCS PACE Agreement is necessary for the continued operation of CalOptima PACE.

**Concurrence**
Gary Crockett, Chief Counsel

**Attachment**

Appendix summary of amendments to PACE Primary Agreements

*/s/ Michael Schrader* *8/28/19*
**Authorized Signature** **Date**

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## APPENDIX TO AGENDA ITEM 7

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.<br><br>Revised capitation rates for the Medi-Cal *Dual* population and *Medi-Cal only* population to have built-in adjustments for Medi-Cal program changes.<br><br>Also incorporated adult expansion group into aid code table:<br>a. Added adult expansion aid codes M1, L1, 7U under adult expansion group.<br>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.<br><br>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.<br><br>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.<br><br>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.<br>*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 |

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| Amendments to Primary Agreement with DHCS | Board Approval |
|---|---|
| **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 |
| **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.<br><br>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.<br><br>Incorporates additional language updates for other contract provisions, including Nursing Facility Services payment rates. | **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 |

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*Continued to a Future Meeting*

**CALOPTIMA BOARD ACTION AGENDA REFERRAL**

**Action To Be Taken September 5, 2019**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**
8. Consider Actions Related to CalOptima's Health Homes Program

**Contact**
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

**Recommended Actions**
1. Authorize and direct the Chief Executive Officer, subject to any revisions required by the California Department of Health Care Services:
   A. To implement the Health Homes Program (HHP) network delivery model for the Medi-Cal program;
   B. With the assistance of Legal Counsel to enter into:
      i. Amendments to the CalOptima Medi-Cal contract with health networks to provide HHP services including responsibilities as Community-Based – Care Management Entities (CB-CMEs);
      ii. An amendment to the Behavioral Health Memorandum of Understanding (MOU) with the Orange County Health Care Agency to reflect coordination of services for CalOptima members with mental health conditions who enroll in Health Homes Program; and
2. Authorize CalOptima staff to conduct a Request for Proposal (RFP) process and to select and contract with a vendor(s) to provide HHP accompaniment and housing related services effective January 1, 2020.

**Background**
The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option. The intent of HHP is to improve member outcomes and reduce health care costs. In California, Assembly Bill 361 (2013) authorizes implementation of the Health Home Program. HHP, which is an entitlement benefit, is being implemented in selected counties in a phased in implementation approach, with Medi-Cal Managed Care Plans (MCPs) operating as lead entities. On June 7, 2018, the CalOptima Board of Directors authorized an amendment to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) to incorporate implementation of the HHP. Implementation in Orange County is expected to be effective no sooner than January 1, 2020 for CalOptima Medi-Cal members with eligible chronic physical conditions and substance use disorders (SUD), and no sooner than July 1, 2020 for CalOptima Medi-Cal members with Serious Mental Illness (SMI).

To support development of HHP, Section 2703 of the ACA provides enhanced funding to states. Rather than the standard Medicaid funding (Federal 50%/State 50%), the Center for Medicare & Medicaid Services (CMS) will fund 90% for the first two years following implementation, effective for each phase. California Assembly Bill 361 requires budget neutrality and that no state general funds are used towards the program. As such, the California Endowment is funding the remaining 10% of funds

for HHP. After the first two years, it returns to the standard Medicaid funding (Federal 50%/State 50%).

Pursuant to the DHCS Program Guide and All Plan Letter 18-012: Health Homes Program Requirements, MCPs will be responsible for overall administration, including development of HHP network. DHCS also published an HHP Program Guide that outlines the responsibilities of the MCPs and CB-CMEs. Per the DHCS requirements, HHP services are to be provided and coordinated through the network of Community-Based Care Management Entities (CB-CMEs). CB-CMEs are responsible for coordinating care with members, providers and other agencies as appropriate. HHP Program Guide requires the following six core service categories for members enrolled in HHP:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Services

DHCS has also established HHP staffing requirements, which are to be utilized across health networks, including: Clinical Consultant; HHP Director; Dedicated Care Coordinator; Housing Navigator for members experiencing homelessness; and, Community Health Worker (recommended, but not required).

Additionally, pursuant to DHCS All Plan Letter 18-015: Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans, MCPs participating in HHP must coordinate care for members enrolled in HHP who also receive care through the Mental Health Plan (MHP or County). The MOU with the Orange County Health Care Agency is the vehicle for ensuring this coordination.

**Discussion**

*HHP Eligible Members and HHP Enrollment*
Members with certain chronic physical conditions, SUD and SMI and meeting specified medical condition acuity requirements may qualify to participate in HHP. In order to participate, members must actively choose to enroll into HHP. Based on DHCS eligibility criteria, CalOptima staff plans to actively outreach to Medi-Cal only members potentially eligible for HHP and actively engage these members through written, telephonic, and face-to-face encounters to encourage member participation in HHP. CalOptima anticipates that approximately 23,000 Medi-Cal only members will be potentially eligible for HHP and that approximately 10% -25% of these eligible members will elect to participate. CalOptima's dually eligible membership will participate in HHP through referrals only.

*HHP Network Delivery Model*
In developing CalOptima's HHP strategy, staff has considered the impact of these new HHP requirements to CalOptima's current delivery system. The impact analysis has included reviewing staffing resources, process and system enhancements, data exchange, and available community resources for new HHP services, such as accompaniment to appointments, housing transition services and tenancy sustaining services. Many of the CB-CME responsibilities are currently being provided by

CalOptima's health networks. For HHP, CalOptima is able to leverage existing infrastructure to incorporate the new HHP services.

HHP focuses on a small percentage of CalOptima's overall membership. Based on the member distribution of HHP enrollment projections within the health networks, CalOptima staff's initial recommended approach was to provide health networks with an option of participating in HHP; however, this approach would potentially have required members to change their health networks and/or primary care providers when enrolling in HHP. In January 2019, DHCS advised that CalOptima must adhere to HHP expectation of not requiring members to change their health networks and/or primary care providers in order to participate in the HHP. Consequently, CalOptima will require all health networks, including CalOptima Direct and CalOptima Community Network, to participate in HHP and meet CB-CME requirements. This approach will provide an adequate CB-CME network and ensure continuity of members' relationships with their respective health networks and primary care providers.

*Health Network Contract*
In order to implement HHP, CalOptima health network contracts will need to be modified to include expectations of CB-CME responsibilities to provide HHP services effective no sooner than January 1, 2020. Prior to implementing HHP, CalOptima will coordinate with the health networks regarding the development of infrastructure, policies and procedures, reporting capabilities, staffing ratio requirements, and the ability to deliver core services with added intensity and new select services, where appropriate

*HHP Select Services*
New HHP services include accompaniment to appointments, housing transition services and tenancy sustaining services. For these new HHP select services, CalOptima staff proposes to conduct Request For Proposal (RFP) processes to procure vendors for these services, with staff conducting the RFPs, and selecting and contracting with vendor(s) to provide services beginning January 1, 2020. Health networks, as CB-CMEs, will have the ability to contract with these selected vendor(s).

*Amendment to County Behavioral Health MOU*
The Behavioral Health MOU between CalOptima and the County of Orange will need to be modified in order to reflect that CalOptima and the County will agree to written policies and procedures for coordinating appropriate services for CalOptima members with mental health conditions who are enrolled in HHP.

*Implementation Efforts*
Based on DHCS feedback and in partnership with the health networks, CalOptima staff continues to develop and modify operational procedures and polices outlining HHP requirements and operational processes impacting member engagement and enrollment, care management, CB-CME network and its responsibilities, staffing requirements and MCP oversight role. CalOptima staff will return to the Board with recommendations for approval of policy and procedures impacted by HHP requirements.

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**Fiscal Impact**
The anticipated implementation date for HHP in Orange County is January 1, 2020. Management has included projected revenues and expenses for HHP in the CalOptima Fiscal Year 2019-20 Operating Budget and will for future operating budgets. Total actual revenue and expenses for HHP will depend on the number of members that choose to participate in the program. Based on projected enrollment and draft rates received from DHCS on April 2, 2018, CalOptima is projected to receive $26.3 million in funding for HHP over a three-year period.

Since this is a new program for CalOptima, there is the possibility that the rate development assumptions applied by DHCS may be materially different from CalOptima's actual utilization and expenses. Should total enrollment fall below thresholds necessary to fund minimum staffing requirements, program costs may exceed projected revenue, resulting in a possible operating deficit of between $3 million and $7 million for the program's three-year period. Staff will closely monitor both utilization and expenses and will continue to work with DHCS to ensure that Medi-Cal revenue will be sufficient to support the program.

**Rationale for Recommendation**
The recommended actions will enable CalOptima to operationally prepare for the anticipated implementation of Health Homes Program, effective January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and SUD and July 1, 2020, for members with SMI.

**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**
1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program
3. Department of Health Care Services. Medi-Cal Health Homes Program, Program Guide 7/1/19
4. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements

*/s/ Michael Schrader* — *8/28/19*
**Authorized Signature** — **Date**

***Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 8***

**CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION**

| Legal 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 |
| ARTA Western California, Inc. | 1665 Scenic Ave Dr, Suite 100 | 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 |
| Kaiser Foundation Health Plan, Inc. | 393 Walnut St | Pasadena | CA | 91188 |
| Monarch Health Plan, Inc. | 11 Technology Drive | Irvine | CA | 92618 |
| Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County | 5785 Corporate Ave | Cypress | CA | 90630 |
| Prospect Health Plan, Inc. | 600 City Parkway West, Suite 800 | Orange | CA | 92868 |
| Talbert Medical Group, P.C. | 1665 Scenic Avenue, Suite 100 | 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 |

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# CalOptima Board Action Agenda Referral

**Action To Be Taken June 7, 2018**
**Regular Meeting of the CalOptima Board of Directors**

**Consent Calendar**

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

**Contact**

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

**Recommended Action**

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

**Background**

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

**Discussion**

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff's understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

| | **Requirement** |
|---|---|
| HHP Compliance | Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs. |
| Provider Network | Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless.<br><br>Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services.<br><br>Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements. |
| Provider Relations | Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives. |
| Eligibility and Enrollment | Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS. |

| | Requirement |
|---|---|
| HHP Member Services | Includes CB–CME selection, and HHP–specific member information and provider directory requirements. |
| HHP Covered Services | Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines. |
| Information Sharing | Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted. |
| Quality Improvement System | Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements. |
| Payment | CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services. |
| Required Reports for the HHP | Submission of reports for HHP in a form and manner specified by DHCS. |

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

**Fiscal Impact**

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

**Rationale for Recommendation**

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

Appendix summary of amendments to Primary Agreements with DHCS

*/s/ Michael Schrader* *5/30/2018*
**Authorized Signature** **Date**

**APPENDIX TO AGENDA ITEM**

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

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

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

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

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)<br><br>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 |

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|---|---|
| **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)<br><br>Ratification of rates requested April 7, 2016 |
| **A-07** extends the Secondary Agreement with the DHCS to December 31, 2020. | December 1, 2016 |

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

| Amendments to Agreement 16-93274 | Board Approval |
|---|---|
| **A-01** extends the Agreement 16-93274 with DHCS to December 31, 2018. | August 3, 2017 |

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

| Amendments to Agreement 17-94488 | Board Approval |
|---|---|
| **A-01** enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004. | December 7, 2017 |

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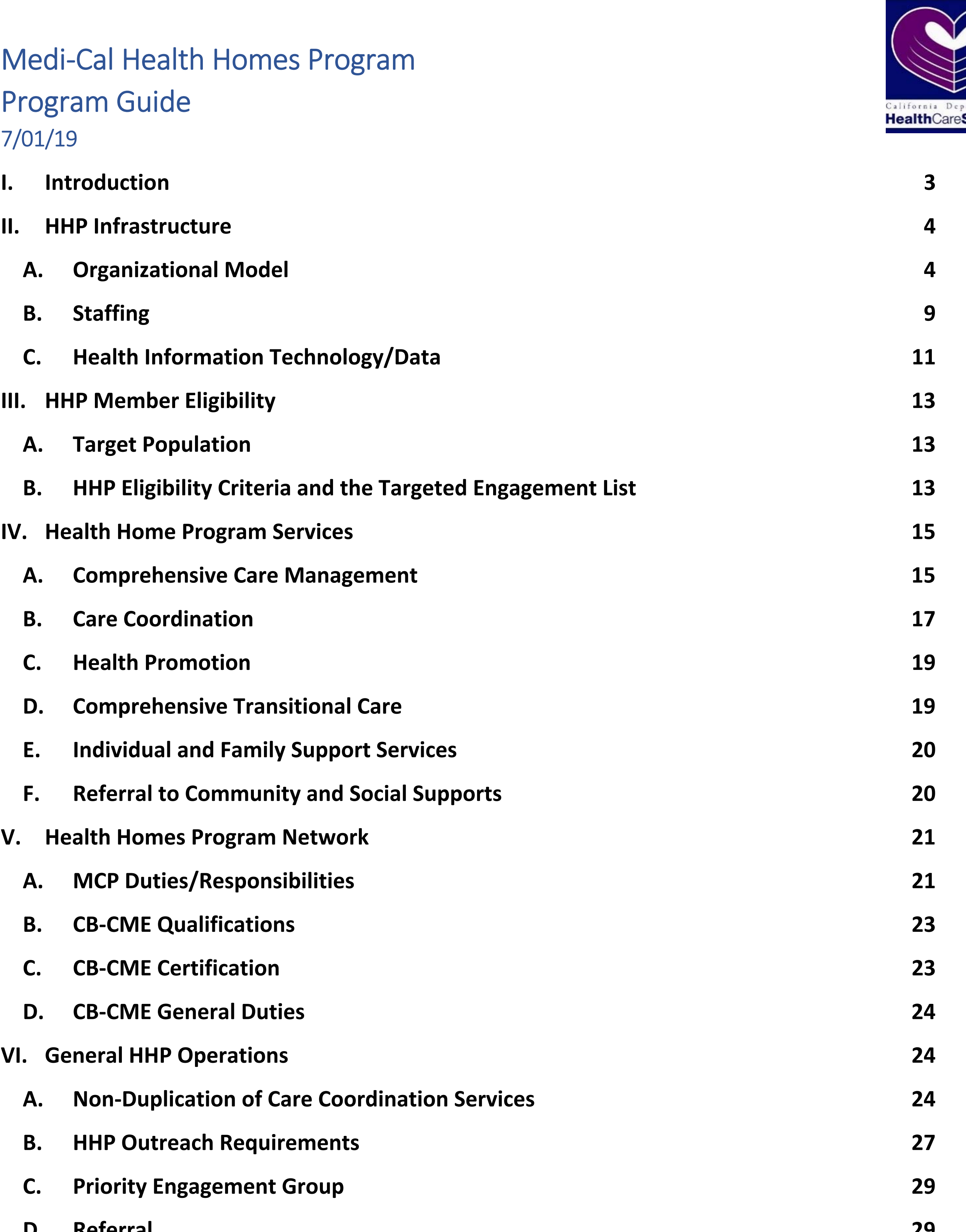

# Medi-Cal Health Homes Program
## Program Guide
7/01/19


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# I. Introduction

The Medi-Cal Health Homes Program: Program Guide (Program Guide) is intended to be a resource for Medi-Cal Managed Care health plans (MCPs) in the development, implementation, and operation of the Health Homes Program (HHP). The Program Guide includes a brief synopsis of the HHP, identifies all HHP requirements, and identifies the documentation MCPs must submit to the Department of Health Care Services (DHCS) as part of the required HHP readiness review. The Program Guide refers to additional guidance documents, when applicable.

The Medicaid Health Home State Plan Option is afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Enhanced federal matching funds of 90% are available for two years.

In California, Assembly Bill 361 (AB 361) amended the Welfare and Institutions Code to add Sections 14127 and 14128 (W&I Code) which authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for members with chronic conditions. The W&I Code provides that the provisions will be implemented only if federal financial participation (FFP) is available and the program is cost neutral regarding State General Funds. It also requires DHCS to ensure that 1) an evaluation of the program is completed; and 2) a report is submitted to the appropriate policy and fiscal committees of the Legislature within two years after implementation of the program.

The Program Guide has five main sections (Infrastructure, Eligibility, Services, Network, and General Operations) and an appendix. Each section describes the program components and the requirements for those components.

The Program Guide contains the Health Homes Program: Medi-Cal Managed Care Plan Readiness Checklist (Readiness Checklist) in Appendix D. The Readiness Checklist identifies the specific components that MCPs are required to provide to DHCS and identifies the process DHCS will use to determine when the specific components are due to DHCS. The Program Guide provides additional guidance and context regarding HHP readiness requirements.



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# II. HHP Infrastructure

## A. Organizational Model

DHCS' HHP implementation will utilize California's Medi-Cal Managed Care (Managed Care) infrastructure as the foundational building block. HHP services will be provided through the Managed Care delivery system to members enrolled in Managed Care. Managed Care serves approximately 85 percent of full scope Medi-Cal members and is an available choice for all full-scope Medi-Cal members statewide. The small percentage of Medi-Cal Fee-For-Service (FFS) members who meet HHP eligibility criteria may enroll in a Medi-Cal MCP to receive HHP services. HHP services will not be provided through the FFS delivery system.

The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP member to a primary care provider. The MCPs' existing communication and reporting capabilities will be utilized to perform health promotion, encounter reporting, and quality of care reporting. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHPs) in each county to facilitate HHP care coordination.

The HHP will be structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP). The HHP network will be developed to meet the following goals:

- Ensure that sufficient HHP funds are available to support care management at the point of care in the community
- Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available as needed
- Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
- Forge new relationships with community provider care management entities, where possible and appropriate
- Utilize community health workers in appropriate roles.

The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long Term Services and Supports (LTSS), oral health services, palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, ED visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between the MCP and the CB-CME, either through direct provision of HHP services,

or through contractual or non-contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

### 1) Medi-Cal Managed Care Plan Responsibilities

HHP MCPs will be responsible for the overall administration of the HHP. They will have an HHP addendum to an existing contract with DHCS. Payment will flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. The MCP may also use HHP funding to pay providers, including but not limited to, the member's primary care physician, behavioral health providers, or other specialists, who are not included formally on the CB-CME's multi-disciplinary care team, for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the Health Action Plan (HAP). These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).

The MCP will have strong oversight and will perform regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.

The MCP's care management department can be leveraged to train, support, and qualify CB-CMEs. (MCPs currently perform similar monitoring, training and auditing with MCP-delegated entities that have care management responsibilities under Cal MediConnect and other programs.)

MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow-up care. MCP health care informatics analytics teams will provide meaningful, actionable data with identification of complex members and care gaps and other pertinent data that the health plan network can access. This will be provided to the CB-CMEs to assist with HAP care planning and ongoing goals for the member.

Many MCPs are exploring housing options to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. Stakeholders include the health plan, hospitals, local housing authorities, and community-based organizations. Achieving stable housing for HHP members is a noted best practice from the national experience for achieving meaningful improvements in health and program cost effectiveness.

In counties selected for HHP implementation, Medi-Cal MCPs (Medicaid only benefit plans) are required to participate in HHP and serve as an HHP MCP. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness.

### 2) Duties

MCPs will be expected to perform the following duties/responsibilities to the extent their information systems allow or through other available methods:

- Attribute assigned HHP members to CB-CMEs;
- Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;

- Notify the CB-CMEs of inpatient admissions and ED visits/discharges;
- Track and share data with CB-CMEs regarding each member's health history;
- Track CMS-required quality measures and state-specific measures (see *Reporting Template* and *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,* or later *document*);
- Collect, analyze, and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process (see *Reporting Template*)
- Provide member resources (e.g. customer service, member grievances) relating to HHP
- Add functionality to the MCP's customer service line and 24/7 nurse line or other available call line so that members' HHP needs are also addressed (e.g. equip nurse line with educational materials to train them about HHP, nurse line receives the updated list of HHP members and their assigned care coordinator, etc.)
- Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and the CB-CME
- Establish and maintain a data-sharing agreement with other providers, with whom MCP shares HHP member health information, that is compliant with all federal and state laws and regulations
- Ensure access to timely services for HHP members, including seeing HHP members after discharge from an acute care stay.
- Encourage participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary care team, but who are responsible for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).
- Develop CB-CME training tools as needed or preferred, in addition to DHCS-provided training
- Develop CB-CME reporting capabilities
- Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

### 3) Community Based Care Management Entity Responsibilities

CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs through a process similar to current MCP provider certification and will contract with selected entities. DHCS will not require MCP use of a standardized assessment tool. DHCS will provide general guidelines

and requirements, including examples of best practice tools that the MCP can use at their option to select, qualify, and contract with CB-CMEs.

The MCP's development of a network of CB-CMEs should seek to promote HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient HHP funding are provided at the point of care in the community;
- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed per AB 361 requirements;
- Leveraging existing county and community provider care management infrastructure and experience, where possible and appropriate; and
- OPTIONAL - Utilizing community health workers in appropriate roles (for more information, see Multi-Disciplinary Care Team below).

CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. DHCS encourages MCPs and CB-CMEs to utilize this flexibility, where needed, to achieve HHP goals, and in particular the four network goals noted above.

In most cases, the CB-CME will be a community primary care provider (PCP) that serves a high volume of HHP eligible members. If the CB-CME is not the member's MCP-assigned PCP, then the MCP and the CB-CME must demonstrate how the CB-CME will maintain a strong and direct connection to the PCP and ensure the PCP's participation in HAP development and ongoing coordination. For all members, and in all areas, the MCP must demonstrate that it is maximizing the four network goals noted above to the full extent possible through its network development and HHP policies. Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP members will receive access to the same level of service, in accordance with the service tier that is appropriate for their needs and HHP service requirements.

DHCS' readiness review will include a detailed review of the MCP's HHP network. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide the full range of CB-CME duties, the MCP may perform needed CB-CME duties to fill a demonstrated service gap. As an alternative, the MCP may subcontract with other entities to perform these duties. In addition, the MCP may provide, or subcontract with another community-based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals. If the MCP utilizes this flexibility, the MCP must demonstrate to DHCS that it is maximizing the four network goals noted above to the



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extent possible, and how it will maintain a strong and direct connection between HHP services and the primary care provider.

The MCP may allow an individual community provider to become a CB-CME after the implementation date of the HHP in their county if the community provider requires additional time to develop readiness to take on some, or all, of the CB-CME duties. The MCP may also allow a CB-CME to expand the range of the CB-CME's contracted CB-CME duties over time as readiness allows.

CB-CMEs that MCPs contract with to deliver HHP care coordination services are not required to be enrolled as Medi-Cal providers, so long as the entities in question are not providing medical and/or clinical services in their function as an HHP CB-CME to Medi-Cal members participating in the Program.

### 4) Community-Based Care Management Models

The main goal of the HHP is Comprehensive Care Management. The MCP, acting as administrator and providing oversight, will build an HHP network in which a member can choose the CB-CME they want for their care coordination. Given specific challenges in certain areas, including the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population, a single model is not practical. Assessments of potential HHP providers, and MCP knowledge of available resources in their areas, will form the basis for determining whether the provider's HHP-eligible members are best served by Model I, II, or III below.

The three community-based care management models below are acceptable for MCP network development and address the realities that exist in various areas of the state regarding available providers. The three models will allow the flexibility to ensure service to all HHP members throughout the diverse geographic regions in California, regardless of location and type of provider empanelment. Further, all three will allow increased care coordination to occur as close to the point of care delivery as possible in the community.

Model I

The first and ideal model embeds care coordinators on-site in community provider offices, acting as CB-CMEs. The expectation is that the community provider will employ these staff, but in some cases they may be employed by the MCP. This model will serve the great majority of HHP members because most HHP eligible individuals are served by high-volume providers in urban areas. The MCP will complete a provider assessment to determine 1) the extent to which the community provider will need to recruit and hire additional staff to meet the HHP care coordinator resource requirements, and 2) what CB-CME duties the community provider can, and is willing to, perform. The HHP will only utilize Model II or III where the provider assessment indicates that Model I is not viable.

Model II

The second model addresses the smaller subset of eligible members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site. For this model, the care management would be handled by another community-based entity or a staff member within

the existing MCP care management department, which will act as the CB-CME. This model will handle HHP members who are not assigned to a county clinic or medical practice under Model I.

Model III

The third model serves the few members who live in rural areas and are served by low-volume providers. In this hybrid model, care coordinators located in regional offices, utilizing technology and other monitoring and communication methods, such as visiting the member at their location, will become CB-CMEs who can be geographically close to rural members and/or those members who are assigned to a solo practitioner who may not have enough membership to meet Model I or II.

## B. Staffing

### 1) Care Coordinator Ratio

The aggregate minimum care coordinator ratio requirement is 60:1 for the whole enrolled population (in each of the MCPs' counties if the MCP has more than one county) as measured at any point in time.

*To develop the aggregate population care coordinator ratio requirement, DHCS assumed that (after two years):*

- *Tier 1 – 20% of population; care coordinator ratio of 10:1*
- *Tier 2 – 30% of population; care coordinator ratio of 75:1*
- *Tier 3 – 50% of population; care coordinator ratio of 200:1*

### 2) Multi-Disciplinary Care Team

The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. DHCS requires the team members listed in Table 1 below to participate on all multi-disciplinary care teams. The team will primarily be located at the CB-CME organization, except as noted above regarding model flexibility. The MCP may organize its provider network for HHP services according to provider availability, capacity, and network efficiency, while maximizing the stated HHP goals and HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member's preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's physical and/or behavioral health service providers, for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's HAP. As an example, an MCP could use HHP care coordination funding to pay a member's specialist provider, who is not a contracted member of the CB-CME Multi-Disciplinary Care Team, for the time they spend participating in a case conference with the HHP care coordinator for the purpose of completing the member's HAP. The MCP may make such payments directly to the providers or through their CB-CME.

**Table 1: Multi-Disciplinary Care Team Qualifications and Roles**

| Required Team Members | Qualifications | Role |
| --- | --- | --- |
| Dedicated Care Coordinator (CB-CME or by contract) | Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse | • Oversee provision of HHP services and implementation of HAP<br>• Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines<br>• Connect HHP member to other social services and supports he/she may need<br>• Advocate on behalf of members with health care professionals<br>• Use motivational interviewing, trauma-informed care, and harm-reduction practices<br>• Work with hospital staff on discharge plan<br>• Engage eligible HHP members<br>• Accompany HHP member to office visits, as needed and according to MCP guidelines<br>• Monitor treatment adherence (including medication)<br>• Provide health promotion and self-management training<br>• Arrange transportation<br>• Call HHP member to facilitate HHP member visit with the HHP care coordinator |
| HHP Director (CB-CME) | Ability to manage multi-disciplinary care teams | • Have overall responsibility for management and operations of the team<br>• Have responsibility for quality measures and reporting for the team |
| Clinical Consultant (CB-CME or MCP) | Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional | • Review and inform HAP<br>• Act as clinical resource for care coordinator, as needed<br>• Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator |

| Required Team Members | Qualifications | Role |
|---|---|---|
| Community Health Workers (CB-CME or by contract) (Recommended but not required) | Paraprofessional or peer advocate<br><br>Administrative support to care coordinator | • Engage eligible HHP members<br>• Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines<br>• Health promotion and self-management training<br>• Arrange transportation<br>• Assist with linkage to social supports<br>• Distribute health promotion materials<br>• Call HHP member to facilitate HHP visit with care coordinator<br>• Connect HHP member to other social services and supports he/she may need<br>• Advocate on behalf of members with health care professionals<br>• Use motivational interviewing, trauma-informed care, and harm-reduction practices<br>• Monitor treatment adherence (including medication) |
| For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract) | Paraprofessional or other qualification based on experience and knowledge of the population and processes | • Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers<br>• Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing<br>• Connect and assist the HHP member to get available permanent housing<br>• Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street) |

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team. It is the responsibility of the MCP to ensure their cooperation.

## C. Health Information Technology/Data

Health Information Technology (HIT)/Health Information Exchange (HIE) are important components of information sharing in the HHP.



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MCPs should consider the following potential uses of HIT/HIE (developed by CMS) in the development of HHP information sharing policies and procedures for MCPs, CB-CMEs, and members:

1) Comprehensive Care Management
    - Identify cohort and integrate risk stratification information.
    - Shared care plan management –standard format.
    - Clinical decision support tools to ensure appropriate care is delivered.
    - Electronic capture of clinical quality measures to support quality improvement.
2) Care Coordination and Health Promotion
    - Ability to electronically capture and share the patient-centered care plan across care team members.
    - Tools to support shared decision-making approaches with patients.
    - Secure electronic messaging between providers and patients to increase access outside of office encounters.
    - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
    - Patient portal services that allow patients to view and correct their own health information.
    - Telehealth services including remote patient monitoring.
3) Comprehensive Transitional Care
    - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER.
    - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR.
    - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.
4) Individual and Family Support Services
    - Patient specific education resources tailored to specific conditions and needs.
5) Referral to Community and Social Support Services
    - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence).
    - Ability to electronically refer patients to necessary services.

Organizations that are covered by the Meaningful Use requirements should utilize EHR/HIT/HIE to meet the applicable goals noted above, where possible. Organizations that are not covered by Meaningful Use may need a Medi-Cal MCP to support the achievement of applicable goals where possible. In some areas relatively few providers have EHRs; there is limited interoperability between the systems; and, where there is an HIE in the area, the configuration may not be designed for the HHP requirements. If the technology environment does not fully support the EHR/HIT/HIE activities noted above in some geographic areas, or with certain providers, the MCP will determine procedures to share information that is critical for HHP services through other methods.

## III. HHP Member Eligibility

### A. Target Population

The HHP is intended to be an intensive set of services for a small subset of Medi-Cal members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of International Classification of Diseases (ICD)-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

### B. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, DHCS will develop a Targeted Engagement List (TEL) of Medi-Cal MCP members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The TEL will be refreshed every six months using the most recent available data. The MCP will actively attempt to engage the members on the TEL. (See Member Assignment, for more information on MCP activity to engage eligible members.)

To be eligible for the HHP, a member must be full-scope, have no share of costs, and meet the following eligibility criteria. See Appendix B for *Targeted Engagement List data specification document* and specific ICD 10 codes that define these eligible conditions:

| Eligibility Requirement | Criteria Details |
|---|---|
| **1. Chronic condition criteria** | Has a chronic condition in at least one of the following categories:<br>• **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR<br>• **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR<br>• **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR<br>• **Asthma** |
| **2. Meets at least 1 acuity/complexity criteria** | • Has at least 3 or more of the HHP eligible chronic conditions; OR<br>• At least one inpatient hospital stay in the last year; OR<br>• Three or more emergency department visits in the last year; OR<br>• Chronic homelessness. |

The TEL may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal members who present the best opportunity for improved health outcomes through HHP services. The DHCS TEL is intended to be used by MCPs as a list of people who are likely to be eligible for the program based on the data available to DHCS; it is not, on its own, a comprehensive eligibility list.

**Acuity Eligibility Criteria**

Eligibility for HHP requires that members have the specified conditions and at least one of the four acuity criteria listed above. MCPs must have a process to verify eligibility as part of the enrollment process. MCPs can do this through reviews of the MCPs data and/or through other methods including discussion/assessment with the member or the member's providers. This additional verification is not only to confirm that the member meets eligibility, but also that they do not have exclusionary criteria such as enrollment in another duplicative care management program or being "well managed." For example, a member's qualifying utilization may have been for something unrelated to management of a chronic condition, such as maternity.

MCPs should make a preliminary eligibility determination based on their data prior to proceeding with proactive outreach and engagement. MCPs may rely on the TEL to verify that the member meets the eligibility criteria for having the eligible chronic conditions and the acuity criteria relating to having three or more of the eligible chronic conditions; however, the MCP should verify utilization acuity criteria (within 12 months) using the MCP's own data.

MCPs are required to review their own data for members who are on the TEL and should not proactively outreach members whose qualifying utilization is: 1) only found in the oldest four months of the TEL look-back period; and 2) unrelated to the HHP chronic conditions. MCPs may also apply their own additional prioritization policies upon approval from DHCS.

At the point in time when the MCP makes this data-driven preliminary eligibility determination, the member will be considered eligible for the program regardless of how long it takes the member to agree to enroll. The member may be enrolled for at least one month to complete the member assessment and care plan process. If additional information is determined during the assessment/care plan process that negates prior eligibility data or confirms an exclusionary criteria, then the member will be disenrolled.

**Homeless Eligibility Criteria**

Chronic homelessness for HHP is defined in W&I Code section 14127(e), and states *"a chronically homeless individual means a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years. For purposes of this article, an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing, as defined in Section 50675.14 of the Health and Safety Code, for less than two years shall be considered a chronically homeless individual if the individual was chronically homeless prior to his or her*

*residence."* For the purpose of verifying HHP acuity eligibility criteria, the portion of this definition which states "with a condition limiting his or her activities of daily living" is satisfied by verification that the member has one of the HHP-eligible conditions. No further assessment of activities of daily living limitation is required to establish that the member meets the portion of this eligibility acuity criterion underlined above. In addition, a member meets the HHP chronically homeless acuity eligibility criteria if the member meets either the W&I Code section 14127(e) definition or the Housing and Urban Development (HUD) definition.

**People Excluded from Targeted Engagement List**

The following exclusions will be applied either through MCP data analysis for individual members or through assessment information gathered by the Community-Based Care Management Entity (CB-CME) (see *Reporting Template-Instructions* for additional information):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program

## IV. Health Home Program Services

This section describes the six HHP services. HHP arranges for and coordinates interventions that address the medical, social, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices available to HHP members.

All HHP engagement and services can be provided to members and family/support persons through e-mails, texts, social media, phone calls, letters, mailings, community outreach, and, to the extent and whenever possible, in-person meetings where the member lives, seeks care, or is accessible. Communication and information must meet health literacy standards and trauma-informed care standards and be culturally appropriate.

### A. Comprehensive Care Management

Comprehensive care management involves activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, trauma-informed care, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and will be reassessed based on the member's progress or changes in their needs. It will also track referrals. The HAP must be completed within 90 days of HHP enrollment.

Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers.

Comprehensive care management services include, but are not limited to:

- Engaging the member in HHP and in their own care
- Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
- Promoting the member's self-management skills to increase their ability to engage with health and service providers
- Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
- Completing a comprehensive health risk assessment to identify the member's needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services
- Developing a member's HAP and revising it as appropriate
- Reassessing a member's health status, needs and goals
- Coordinating and collaborating with all involved parties to promote continuity and consistency of care
- Clarifying roles and responsibilities of the multi-disciplinary team, providers, member and family/support persons

### 1) Care Management Assessment Tools

To the extent possible and reasonable, DHCS will align new requirements for care management methods and tools with those currently used by MCPs for care coordination. MCPs have extensive experience administering Health Risk Assessments and developing care plans.

MCPs may use current Cal MediConnect or Seniors and Persons with Disabilities (SPD) care management tools, such as the Health Risk Assessment and Individualized Care Plan, as a base for developing health assessments and completing the HAP for HHP members. For the implementation of HHP, any assessment or planning elements that are required in the HHP and are not already included in an existing tool and/or process must be added to the existing MCP assessment and planning tools. Such elements could include an assessment of social determinants of health, including an indicator of housing instability, a need for palliative care, and trauma-informed care needs.

The HAP is defined as the Individualized Care Plan with the inclusion of any elements specific to HHP. When a member begins receiving HHP services, the member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed at regular intervals and when changes occur in the member's progress or status and health care needs.

The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care coordinators for all HHP members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities, the care coordinator will work with the HHP member and their family/support persons to develop a HAP.

### 2) Duties

MCPs in partnership with CB-CMES must be able to carry out the following comprehensive care management services:

Member Engagement and Support

a. MCPs must ensure that CB-CMEs accomplish the following:
   1) Engage the member in the HHP and their own care
   2) Assess the HHP member's readiness for self-management using standardized screenings and assessments with standardized tools
   3) Track and promote the member's self-management skills to increase their ability to engage with health and service providers
   4) Support the achievement of the member's self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines

Member Assessment

a. MCPs/CB-CMEs must have a process for assessing and reassessing the member to identify their needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services. The process should identify:
   1) How their tools align with current tools used for the defined population and avoid unnecessary duplication of assessment?
   2) How trauma-informed care best practices will be utilized?
   3) Whether the assessment process and HAP are standard across the CB-CMEs or whether variations exist.
b. MCPs/CB-CMEs must have a process and tools for developing the member's HAP and revising, as appropriate
c. MCPs/CB-CMEs must develop and use the HAP and screening and assessment tools, and develop processes for:
   1) How the HAP is shared with other providers and if it can be shared electronically; and
   2) How the HAP will track referrals and follow ups.

Coordination

a. MCPs/CB-CMEs must have a process for integrating community social supports, long term support services, mental health, substance use disorder services, palliative care, trauma-informed care, oral health, and housing services into a member's HAP
b. MCP must ensure that the CB-CMEs:
   1) Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and
   2) Clarify roles and responsibilities of the multi-disciplinary team, providers, HHP member, and family/support persons.
c. MCPs must have policies and procedures to ensure that members are not receiving the same services from another state care management program (see non-duplication of care coordination services for more information).

## B. Care Coordination

Care coordination includes services to implement the HHP member's HAP. Care coordination services begin once the HAP is completed. HHP care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current

MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all service providers. All program staff who provide HHP services are required to complete CB-CME/care coordinator training as discussed in Appendix C.

Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

1) Member Support
   - Working with the member to implement their HAP
   - Assisting the member in navigating health, behavioral health, and social services systems, including housing
   - Sharing options with the member for accessing care and providing information to the member regarding care planning
   - Identifying barriers to the member's treatment and medication management adherence
   - Monitoring and supporting treatment adherence (including medication management and reconciliation)
   - Assisting in attainment of the member's goals as described in the HAP
   - Encouraging the member's decision making and continued participation in HHP
   - Accompanying members to appointments as needed

2) Coordination
   - Monitoring referrals, coordination, and follow ups to ensure needed services and supports are offered and accessed
   - Sharing information with all involved parties to monitor the member's conditions, health status, care planning, medications usages and side effects
   - Creating and promoting linkages to other services and supports
   - Helping facilitate communication and understanding between HHP members and healthcare providers

MCPs in partnership with CB-CMEs must develop, and ensure the implementation of, policies and procedures to support CB-CME coordination efforts to:

a. Maintain frequent, in-person contact between the member and the care coordinator when delivering HHP services. Minimum in-person visits for the aggregated population is 260 visits per 100 enrolled members per quarter. DHCS used the following assumptions to develop the aggregate population visit requirement listed above:
   i. After two years, the population equals: 20% in tier 1, 30% in tier 2, 50% in tier 3
   ii. Tier 1 – two in-person visits per month
   iii. Tier 2 – 1 in-person visit per month
   iv. Tier 3 – 1 in-person visit per quarter
b. Ensure members see their PCP within 60 days of enrollment in HHP. This is a recommended best practice only – not service requirement.
c. Ensure availability of support staff to complement the work of the Care Coordinator.
d. Ensure availability of providers with experience working with people who are chronically homeless.
e. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions.

f. Link eligible individuals who are homeless or experiencing housing instability to permanent housing, such as supportive housing.
g. Maintain an appointment reminder system for members. This is a recommended best practice only – not a service requirement.
h. Identify and take action to address member gaps in care through:
    i. Assessment of existing data sources for evidence of care appropriate to the member's age and underlying chronic conditions
    ii. Evaluation of member perception of gaps in care
    iii. Documentation of gaps in care in the member case file
    iv. Documentation of interventions in HAP and progress notes
    v. Findings from the member's response to interventions
    vi. Documentation of discussions of members care goals
    vii. Documentation of follow-up actions, and the person or organization responsible for follow-up

## C. Health Promotion

Health promotion includes services to encourage and support HHP members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

Health promotion services include, but are not limited to:

- Encouraging and supporting health education for the member and family/support persons
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
- Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Linking the member to resources for: smoking cessation; management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care

## D. Comprehensive Transitional Care

Comprehensive transitional care includes services to facilitate HHP members' transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, MCPs or CB-CMEs must provide information to hospital discharge planners about HHP.

Comprehensive transitional care services include, but are not limited to:

- Providing medication information and reconciliation
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
- Collaborating, communicating, and coordinating with all involved parties
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
- Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures
- Developing and facilitating the member's transition plan
- Preventing and tracking avoidable admissions and readmissions
- Evaluating the need to revise the member's HAP
- Providing transition support to permanent housing

## E. Individual and Family Support Services

Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

Individual and family support services may include, but are not limited to:

- Assessing the strengths and needs of the member and family/support persons
- Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
- Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
- Accompanying the member to clinical appointments, when necessary
- Identifying barriers to improving the member's adherence to treatment and medication management
- Evaluating family/support persons' needs for services

## F. Referral to Community and Social Supports

Referral to community and social support services involves determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources, and following up with the members.

Community and social support referral services may include, but are not limited to:

- Identifying the member's community and social support needs
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
- Providing member with information on relevant resources, based on the member's needs and interests.
- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
- Following up with the member to ensure needed services are obtained
- Coordinating services and follow-up post engagement
- Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
- Providing Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing
- Providing Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy

## V. Health Homes Program Network

### A. MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities:

a. Develop and implement criteria for network sufficiency determination, including county-wideness and number of projected members
b. Develop an adequate network of Community-Based Care Management Entities (CB-CMEs) in each of the MCP's implemented counties for HHP to serve enrolled members
c. Design and implement a process for determining the qualifications of organizations to meet CB-CME standards and for providing support for CB-CMEs, including:
    1. Identify organizations who meet the CB-CME standards
    2. Provide the infrastructure and tools necessary to support CB-CMEs in care coordination
    3. Gather and share HHP member-level information regarding health care utilization, gaps in care and medications
    4. Provide outcome tools and measurement protocols to assess CB-CME effectiveness
d. Integrate community entities focused on services to individuals experiencing homelessness into the care model and, if applicable, the multi-disciplinary care team; meet the State legislation requirement to ensure availability of providers with experience working with individuals who are chronically homeless.

e. Engage with community and social support services by building new, or enhance existing, relationships with programs, services, and support organizations to provide care to members, including but not limited to:
    1. County specialty mental health plans;
    2. Housing agencies and permanent housing providers; and
    3. Individual Housing and Tenancy Sustaining Services.

f. Contract with CB-CMEs for the provision of HHP services, including outlining the MCP and CB-CME roles and responsibilities, and ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, including the network development goals.

g. Have methods to ensure compliance with HHP requirements throughout the network, including portions of the network contracted through delegated entities.

h. Ensure the development of a communication and feedback strategy for all members of the HHP care team, including the member and their family/support persons, to ensure information sharing occurs. Encourage all of the HHP member's providers who supply input to the HAP and coordinate with the CB-CME care coordinator to conduct case conferences, including with those whom may not be formally included on the CB-CME's multi-disciplinary care team.
    1. If the CB-CME is not the member's MCP-assigned PCP, the MCP must have policies and procedures for ensuring: the MCP/CB-CME maintains a strong and direct connection to the PCP and PCP's participate in HAP development and ongoing coordination.

i. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

### 1) Administration

a. Attribute assigned HHP members to CB-CMEs, providing for increased care coordination as close to the member's usual point of care delivery as possible in the community. HHP members must be notified of their CB-CME options.

b. Receive payment from DHCS and disperse funds to CB-CMEs. Have policies and procedures regarding:
    1. The process for how an MCP determines that the appropriate level of services are provided and documented by CB-CMEs in accordance with the contract and service requirements; and
    2. The process/structure/tiering (if used) for payments to CB-CMEs.

### 2) Data Sharing and Reporting

a. Develop reporting capabilities and methodologies

b. Establish and maintain data-sharing agreements that are compliant with all federal and state laws and regulations, and when necessary, with other providers

c. Notify CB-CMEs of inpatient admissions and emergency department (ED) visits/discharges

d. Track and share data with CB-CMEs regarding each member's health history

e. Establish procedures for hospitals participating under the Medicaid State Plan or a waiver of such plan for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated HHP providers. However, HHP primarily uses the TEL to identify and refer members to HHP.

3) Training and Education

a. Develop and offer learning activities that will support CB-CMEs in effective delivery of HHP services
b. Develop CB-CME training tools, as needed, to supplement DHCS-developed tools.
c. Ensure participation of the CB-CME and MCP staff delivering HHP Services in DHCS-required CB-CME and care coordinator training and learning collaboratives.

## B. CB-CME Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with W&I Code HHP requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed. If in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized, if culturally appropriate and accessible for the HHP member, to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by the MCP, according to the CB-CME contract with the MCP;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and MCP and other providers involved in the HHP member's care.

## C. CB-CME Certification

Organizations must be one of the following types of organizations and be able to meet the qualifications above and perform the duties below to be authorized to serve as a CB-CME:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health center
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group

- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the MCP

### D. CB-CME General Duties

CB-CMEs will be expected to perform the following duties/responsibilities:

- Be responsible for care team staffing, according to HHP required staffing ratios determined by DHCS, and oversight of direct delivery of the core HHP services;
- Implement systematic processes and protocols to ensure member access to the multi-disciplinary care team and overall care coordination;
- Ensure person-centered health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical physical and behavioral health care related needs and services, and social services needs and services;
- Collaborate with and engage HHP members in developing a HAP and reinforcing/implementing/reassessing it in order to accomplish stated goals;
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure that the HHP member care is integrated among providers;
- Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and to improve health;
- Provide evidence-based care;
- Monitor referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up;
- Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
- Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);
- Provide service in the community in which the HHP member lives so services can be provided in-person, as needed;
- Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP member; and
- Provide quality-driven, cost-effective HHP services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy.

## VI. General HHP Operations

### A. Non-Duplication of Care Coordination Services

MCPs must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving HHP care coordination services. The process should include: 1) checking available MCP data; and 2) asking members as part of

both the in-person member assessment during the eligibility/enrollment process and the assessment/care plan process.

The Targeted Engagement List (TEL) does not include members who are participating in the following programs:

- 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH);
- County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);
- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month; and
- Hospice.

Below is a summary of how HHP intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: 1) Members can receive services through both HHP and the other program; 2) Members must choose HHP or the other program; and 3) Members cannot receive HHP services.

### 1) Members Can Receive Services through BOTH HHP and the Other Program

- 1115 Waiver Whole Person Care Pilot Program
  Members participating in a Whole Person Care (WPC) Pilot Program may also be eligible for the HHP. DHCS has released specific guidance related to the interaction between the Health Homes Program and the WPC Pilot Program which can be found in Appendix K of this Program Guide.

- California Children's Services
  Children who are enrolled in the Children's Services program are eligible for the HHP.

- Specialty Mental Health and Drug Medi-Cal
  DHCS recognizes that coordination of behavioral health services will be a major component of HHP. HHP services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, trauma-informed care, oral health, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP members will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP members who receive behavioral health services have the capability to support the various needs of their members.

  For HHP members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented CB-CME is an appropriate setting for their HHP services. These CB-CMEs would typically be affiliated with an MCP.

  DHCS and stakeholders have noted that HHP members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary HHP services from their MHP's contracted provider acting as a designated CB-CME. To

facilitate care coordination for HHP members through a MHP-designated CB-CME, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform CB-CME HHP responsibilities through a contract with the MCPs in the county at the discretion of the MCP. This type of entity would perform the CB-CME HHP responsibilities for an HHP-eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated CB-CME instead of a CB-CME affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the CB-CME.

### 2) Members Must Choose HHP OR the Other Program

- Targeted Case Management
  County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and is duplicative of HHP. Members who are receiving TCM services have a choice of continuing TCM services or receiving HHP services.

  However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of HHP. The HHP provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

- 1915(c) Waiver Programs
  1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for HHP. There are comprehensive care management components within these programs that are duplicative of HHP services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving HHP services.
  The 1915(c) HCBS waiver programs include:
  HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), and Nursing Facility Acute Hospital (NF/AH).

- Cal MediConnect or Fee-for-Service Delivery Systems
  Members who are eligible for both Medi-Cal and Medicare are eligible for the HHP. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the HHP. However, HHP is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for-Service delivery systems to receive all their Medi-Cal services, including HHP services, through a regular Medi-Cal Managed Care Plan.

- Other Comprehensive Care Coordination Programs
  Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of HHP services, including programs that are operated or overseen by the MCP. Examples include, but

are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

### 3) Members CANNOT Receive HHP Services

- Nursing Facility Residents and Hospice Recipients
  Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the HHP.

## B. HHP Outreach Requirements

MCPs will be responsible for engaging HHP-eligible members, using state-determined, Centers for Medicare & Medicaid Services (CMS)-approved criteria. Engagement of eligible HHP members will be critical for the program success. MCPs will link HHP members to one of the MCP's contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider (PCP) is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions.

### 1) MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities or delegate to CB-CMEs and provide appropriate oversight.

a. Capacity
   Have the capacity to engage and provide services to eligible members, including:
   1) Establish an engagement plan with appropriate modifications for members experiencing homelessness;
   2) Evaluate the TEL provided by DHCS;
   3) Attribute assigned HHP members to CB-CMEs;
   4) Ensure the engagement of members on the targeted engagement list;
   5) Secure and maintain record of the member's consent to participate in the program (which can be verbal); and
   6) Provide member resources (e.g. customer service, member grievance process) relating to HHP.

b. Engagement Process
   1) Have policies and procedures for identifying, locating, and engaging HHP-eligible members.
   2) Use the following strategies for engagement as appropriate and to the extent possible: mail; email; social media; texts; telephone; community outreach; and in-person meetings where the member lives, seeks care, or is accessible.
   3) Show active, meaningful and progressive attempts at member engagement each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face-to-face, mail, electronic, telephone), follow-up if the member presents to another partner in the HHP network, or using claims data to contact providers the member is known to use. Examples of acceptable engagement include:

    a. Letter to member followed by phone call to member
    b. Phone call to member, outreach to care delivery partners and social service partners
    c. Street level outreach, including, but not limited to, where the member lives or is accessible
4) Establish a process for reviewing and excluding people from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines of having no substantial avoidable utilization or be enrolled in another acceptable care management program – see Reporting Template-Instructions for definition);
5) Report Members determined not appropriate for the HHP, along with a reason code, to DHCS.
6) DHCS will evaluate the MCP enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the targeted engagement list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.
7) Include housing navigators in the engagement process, at the MCP's discretion
8) Document the member engagement process
9) Develop a methodology and criteria used by the MCP or the CB-CME to stratify high, medium and low need members
10) Develop educational materials or scripts that you intend to develop to engage the member.
11) Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma-informed care standards
12) Have policies and procedures for the following:
    a. Required number and modalities of attempts made to engage member
    b. MCP's protocol for follow-up attempts
    c. MCP's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate

c. Assignment

MCPs will link HHP members to one of their contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions. MCP's and/or CB-CME's notification will inform the HHP member that they are eligible for HHP services, and identify their MCP and CB-CME. This notification will explain that HHP participation is voluntary, members have the opportunity to choose a different CB-CME, and HHP members can discontinue participation at any time. It will also explain the process for participation. In counties where multiple MCPs are available, the HHP member may change their MCP once per month in accordance with current MCP choice policies.



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## C. Priority Engagement Group

After the MCP has screened people who are inappropriate for HHP from the TEL based on the HHP requirements, MCPs are required to create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for priority engagement status will be at the MCP's discretion (upon approval by DHCS).

## D. Referral

HHP services must be made available to all full scope Medi-Cal members without a share of cost who meet the DHCS-developed eligibility criteria, including those members dually eligible for Medicaid and Medicare. Providers, health plan staff, or other, non-provider community entities/care providers may refer eligible members to the member's assigned MCP to confirm if the member meets the eligibility criteria to receive HHP services. The Targeted Engagement List will be the primary method for identifying and engaging eligible HHP members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims history that identifies them as HHP eligible. Provider referral forms will indicate that the provider has verified that the member meets the HHP eligibility criteria. The provider will submit the referral form to the MCP for confirmation. MCP confirmation is required before an individual is deemed an HHP member and may receive HHP services from a CB-CME.

## E. Consent

The member will be considered enrolled in the HHP once the member has given either verbal or written consent to participate in the program. The MCP or CB-CME will secure consents by the member to participate in HHP and authorize release of information to the extent required by law. Either the MCP or the CB-CME must maintain a record of these consents.

## F. Disenrollment

If an eligible member has, or develops, an exclusionary criterion, cannot be engaged within a specified period, chooses not to participate, or fails to participate actively in HHP planning and coordination, the HHP member will be disenrolled from the HHP, and the MCP will discontinue CB-CME HHP funding for that member. Additionally, if the MCP determines that the member's eligible chronic conditions have become well-managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status – the HHP member will be disenrolled and the MCP will discontinue CB-CME HHP funding for that member.

A Notice of Action (NoA) Letter is required in all situations except for when an eligible member chooses not to participate. The eligible member may choose to participate in the HHP at any time.

## G. Risk Grouping

The MCP will ensure that HHP member acuity will inform appropriate provision of HHP services. For example, MCP program criteria may include three, or more, risk groupings of the HHP members. Members in the higher acuity risk groupings (tiers) will receive more intensive HHP services. In addition, the HHP will include requirements to address the unique needs of members experiencing homelessness, as specified in AB 361.

## H. Mental Health Services

MCPs will develop or amend existing Memoranda of Understanding with county Mental Health Plans (MHPs) to address HHP-specific information. DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018) to address the HHP-specific information that MCPs must include in new, or amended, MOUs. This MOU will be submitted to DHCS prior to the start of HHP implementation for the Serious Mental Illness or Serious Emotional Disturbance (SMI) population. Please see Appendix D - Readiness Requirements and Checklist for information on this deliverable.

## I. Housing Services

MCPs will work with community resources to ensure seamless access to the delivery of housing support services. MCPs or contracted CB-CMEs must provide housing navigation services, not just referrals to housing. A Housing Navigator is required to be part of the HHP care team for members experiencing homelessness. HHP members must receive the following services:

### 1) Individual Housing Transition Services

Housing transition services assist beneficiaries with obtaining housing, such as individual outreach and assessments. These services include:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;
- Assisting with the housing application process. Assisting with the housing search process;
- Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
- Ensuring that the living environment is safe and ready for move-in;
- Assisting in arranging for and supporting the details of the move; and
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

### 2) Individual Housing and Tenancy Sustaining Services

Housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;
- Education and training on the roles, rights and responsibilities of the tenant and landlord;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;
- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

To the extent applicable, housing-based case management services provided to HHP members shall be consistent with the Housing First core components as described in Senate Bill (SB) 1380 Mitchel, Chapter 847, Statutes of 2016). Engagement to members potentially eligible for HHP or the provision of HHP housing-based case management services may not be restricted for individuals based on sobriety, completion of treatment, poor credit, financial history, criminal background, or housing readiness, unless they are determined ineligible for HHP or meet one or more of the DHCS defined HHP exclusionary criteria. HHP housing-based services shall incorporate a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of members' lives, where members are engaged in nonjudgmental communication regarding drug and alcohol use. Members should be offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if they so choose.

The HHP does not provide direct funding for housing. However, DHCS encourages MCPs to partner with housing organizations that incorporate the Housing First model into their case management and housing navigation services offered to members and to prioritize connecting HHP members with permanent housing options, when appropriate and available. For example, plans might explore collaborating with community-based organizations that are Housing First compliant, implement a requirement that housing services be provided consistent with Housing First components, encourage enhanced coordination with coordinated entry and assessment systems and/or allow receipt of referrals from the homeless crisis response system entities.

The goal is to integrate Housing First principles and components in an effort to enhance the provision of meaningful individual housing and tenancy-sustaining services to enrolled members.

## J. Training

MCPs are required to ensure that the MCP and CB-CME staff who will be delivering HHP services receive the required HHP training prior to participating in the administration of the HHP. See Appendix C for training requirements.

## K. Service Directory

MCPs or CB-CMEs must ensure a directory of community services and supports is developed, maintained, and is made available to all care coordinators to inform referring members to social services. The community services directory may be sourced from existing directories so long as it is available as a resource for CB-CMEs and care coordinators. This type of directory may be maintained by either the MCP or the CB-CME; however, the contracted MCP will ensure its availability.

## L. Quality of Care

MCPs must incorporate HHP into existing quality management processes.

MCPs must have the capacity to collect and track information used to manage and evaluate the program, including tracking quality measures, and collecting, analyzing, and reporting financial measures, health status and other measures and outcome data to be reported for the State's evaluation process. The MCP will report core service metrics and the recommended core set of health care quality measures established by CMS, as well as the three utilization measures identified by CMS to assist with the overall federal health home evaluation. MCPs must report on the measures listed in the *Reporting Template, and provide* encounters for all HHP services.

## M. Cultural Competency, Educational and Health Literacy

MCPs must incorporate HHP into existing policies and procedures related to ensuring that services, communication, and information provided to members are culturally appropriate, and meet health literacy, reading, harm-reduction, and trauma-informed care standards.

## N. Member Communication

MCPs must incorporate HHP into existing policies and procedures regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers) into account in communicating with enrollee. DHCS and DMHC will review member materials from Knox-Keene plans through the usual process and criteria. DHCS will use a parallel process for non-Knox-Keene plans.

All notices to be sent by the MCP to Medi-Cal beneficiaries regarding the provision of HHP services will be submitted to DHCS for review.

Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. MCPs may use the DHCS HHP Member Handbook as an optional resource for examples of "best practice" member messaging (though the Handbook messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

MCPs must maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.

## O. Members Experiencing Homelessness

MCPs must incorporate HHP-specific information into the appropriate policies and procedures for homeless members, including special provider and service requirements criteria (to achieve homeless experience requirements and other requirements per AB 361 and SB 1380), and engagement processes.

## P. Reporting

MCP must have the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP encounters for services provided by the MCP and the CB-CMEs. See Appendix G (*Reporting Template);* and the *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting,* or later, for details.

CMS has established a core set of seven required health care quality measures and three utilization measures (see *Reporting Template* and *document* for details). Additional details can be found in the CMS technical specifications and resource manual. These measures were identified by CMS to assist with the overall federal health home evaluation.

MCPs will utilize the Supplemental Payment process to report members enrolled in HHP and to initiate capitation payments. See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information.

# VII. Appendix

## A. Appendix A – Example of an Acceptable Model Outreach Protocol

***This Model Outreach Protocol is only offered as one example of a protocol that would be acceptable. It is meant to give the MCP ideas about how they might want to design their outreach protocols with the CB-CMEs. The details of this protocol are at the discretion of the MCP, as long as their protocol broadly meets DHCS' intent as stated in the body of the Program Guide and the Readiness Checklist.***

***SAMPLE PROTOCOL***

The Medi-Cal managed care plan (MCP) will send an initial "Welcome Packet" to HHP-eligible members in accordance with their engagement process. After the initial packet is sent, the CB-CMEs will follow up with their HHP-eligible members through phone calls, in-person visits, and other modalities. Each CB-CME or the MCP will attempt to contact the member **five times** within 90 days after the initial packet is sent using various modes of communication (letters, calls, in-person meetings, etc.).

If the CB-CME does not have the capacity to conduct outreach to eligible members, MCP care coordination staff, including community health workers, will conduct the outreach to these members and note the outreach attempts in the members' record.

After five attempts, the CB-CME and the MCP will note the challenges with the active outreach and remind the PCP to discuss the HHP with the member at the next PCP visit. If the member declines HHP enrollment at the PCP visit, this will be noted in the EHR and the MCP will be notified.

If the CB-CME or the MCP learns that the contact information is out of date, efforts will be made to update that information using recent provider utilization data and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations. The CB-CME will also review members' housing history and work with the MCP Housing Program Manager to determine if that member can be reached at an alternative housing site or through a community-based organization.

CB-CMEs will track all outreach attempts within a three month intensive outreach period after the initial welcome letter is sent. The MCP will require that each outreach attempt and the outcome of each attempt be documented in the member's record in the HHP care management system and reported back to the MCP and DHCS. All outreach and engagement attempts will be evaluated by the care coordination team every 30 days within this three month period. The MCP will create policies and procedures for tracking and evaluating outreach and engagement efforts.

If a member declines participation in the HHP, or if their PCP determines that the member is not a good candidate for the HHP (using categories determined and provided by DHCS), this will be noted in the record in the HHP care management system to avoid repeated outreach



SAMPLE

attempts. Members who do not enroll in the HHP will be noted, tracked in the MCP's data system and reported to DHCS. Members who graduate from the program will be disenrolled, which will be noted in the record, tracked in the data system, and reported to DHCS.

The MCP will create a mechanism for CB-CMEs and PCPs to identify potential HHP members who are not on the targeted engagement list and who meet the diagnostic and acuity criteria but not the utilization criteria. These individuals may be excellent candidates for the program to help prevent future avoidable health care utilization. In general, MCP will require CB-CMEs to justify the inclusion of the referred member into the program or onto the targeted engagement list. This would be reviewed by a medical director and/or nurse manager with experience in intensive case management to see if the member qualifies for the HHP or if they might be better served by another case management program, and if the rationale provided by the CB-CME or PCP justifies engagement and enrollment in the program.

*Staff and Providers*

The MCP will train MCP and CB-CME staff who may interact with HHP members, including customer service staff, 24-hour nurse line staff, and provider representatives, to ensure all member- and provider-facing staff are knowledgeable about the HHP, can answer questions and refer participating or eligible members or providers to the appropriate staff. MCP staff, CB-CME staff, providers and community providers are required to participate in webinars and trainings required by DHCS.

The MCP will work to educate all contracted providers, including providers at contracted CB-CMEs and providers from smaller clinics whose patients will receive HHP services through MCP care coordinators.

There will be on-the-ground community health workers who work in the local community and will visit members at their homes or community-based organizations where the members receive services. The MCP has made significant investments in developing this team of community health workers and they will be a key part of success in engaging and educating members on HHP.

*Materials*

The MCP will work with DHCS to educate providers, beneficiaries and key stakeholders to ensure strong member engagement and participation. The MCP will use outreach and education materials (flyers, brochures, sample email content, sample scripts, etc.) that are approved by DHCS. If the MCP is licensed by DMHC, these materials should additionally be filed with DMHC for review, as applicable. The MCP will also use existing communication channels to promote outreach and education opportunities for providers and members, such as informational webinars, trainings and tele-town halls.

At a minimum, the MCP will develop the following materials:

- Call scripts for Customer Service and 24-hour Nurse Advise Line;
- Member "Welcome Packet," including outreach letters and brochures;



SAMPLE

- Appointment reminder letters for both medical and care coordination appointments;
- Content for both the member and provider sections of the MCP website; and
- Training guides for the MCP and CB-CME staff who interface with providers and members.

All member-facing materials for HHP will meet DHCS requirements for cultural competency and health literacy standards.

SAMPLE

## B. Appendix B – Targeted Engagement List Process

The Targeted Engagement List (TEL) Process identifies the Medi-Cal members that are the most appropriate candidates for the enhanced care coordination services in the Health Home Program (HHP). The TEL is sent to each participating Managed Care Plan (MCP) so that they can initiate engagement activities. This document provides additional details for the criteria and steps used in the TEL Process.

The data source for the TEL Process is DHCS's Data Warehouse. The Data Warehouse contains service level detail for most Medi-Cal programs, including managed care encounters, Fee-For-Service claims, Short-Doyle Mental Health services, Drug-Medi-Cal services, and others. MEDS eligibility information available in the Data Warehouse is also used in the TEL Process.

TEL Process – There are four main steps in the TEL Process, as follows:

1. SPA Eligibility Requirements for Chronic Condition Disease Identification – During the 24 months prior to the running of the TEL, if a member has at least two separate services on different dates for any of the following conditions it will be considered a chronic condition for the TEL. HHP chronic conditions include Asthma, Bipolar Disorder, Chronic Kidney Disease (CKD), Chronic Liver Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic or Congestive Heart Failure, Coronary Artery Disease, Dementia, Diabetes, Hypertension, Major Depression Disorders, Psychotic Disorders (including Schizophrenia), Substance Use Disorder, and Traumatic Brain Injury. The specific ICD-10 diagnosis codes for each chronic condition are listed below. The TEL process uses the primary and secondary diagnosis during the disease identification process.

2. SPA Eligibility Requirements for Chronic Condition Criteria. A member meets the chronic condition criteria if they have:
   - 2.1. Chronic Condition Criteria #1: At least two of the following: Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, Substance Use Disorder.
   - 2.2. Chronic Condition Criteria #2: Hypertension and one of the following: COPD, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure.
   - 2.3. Chronic Condition Criteria #3: One of the following: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders (including Schizophrenia).
   - 2.4. Chronic Condition Criteria #4: Asthma

3. SPA Eligibility Requirements – Acuity – These parameters ensure that potential HHP members are high utilizers of health services. A member must meet one of these acuity factors:

3.1. A high chronic condition predictive risk level (operationalized as three or more of the HHP eligible chronic conditions) or

3.2. At least one inpatient stay (not required to be related any particular condition*) in the 16-month period prior to the running of the TEL. (The inpatient stay algorithm is aligned with industry standards and the HEDIS inpatient algorithm) or

3.3. Three or more Emergency Department (ED) visits (not required to be related to any particular condition*) in a 16-month period prior to the running of the TEL. (The ED algorithm is aligned with industry standards and the HEDIS ED algorithm) or

3.4. Chronic Homelessness (there are no data parameters for this criteria. Members who only meet eligibility through this criteria will be identified solely through provider referral and MCP prior authorization)

* MCPs have the option to adjust this requirement.

4. HHP Enrollment Targeting and Exclusions – This step starts with the Medi-Cal members that meet the SPA chronic conditions and acuity eligibility requirements and determines if the members meet any of the specific program enrollment targeting and exclusionary criteria.:

   a) Members that meet the eligibility requirements are excluded from the TEL, and <u>are excluded from participation in HHP unless their status changes</u>, if the members are identified as:

   - Nursing Facility Residents
   - Hospice Recipients
   - Members with TCM
   - Members in 1915 (c) programs
   - Members in Fee-For-Service
   - Members in PACE, SCAN, or AHF
   - Members in Cal MediConnect

   b) Members that meet the eligibility requirements are not included on the TEL (but could be enrolled through referral) if the members are identified as:

   - Dually eligible members
   - Members in CCS or GHPP
   - Members with ESRD

TEL and TEL Supplement Reporting

The members that meet the eligibility requirements for chronic conditions and acuity will be reported to the managed care plans (MCPs) in either the TEL or the TEL Supplement. The TEL will contain all of the members that meet the SPA eligibility criteria through step 3 above and do not meet any of the specific program enrollment targeting and exclusionary criteria listed in step 4. The MCPs will use the TEL, their TEL verification process, and their internal priority

engagement rules to focus their enrollment activities and enroll the most appropriate members into HHP. The TEL Supplement will contain members that meet the SPA eligibility requirements for chronic condition criteria but are not included on the TEL. The TEL and the TEL Supplement will be provided within the same physical data set with the appropriate indicators.

TEL and TEL Supplement List Management

DHCS' expectations are that most of the HHP eligible members will be identified on the first TEL/TEL Supplement for an MCP in a region (first for chronic conditions, and six months later, for SMI) and most subsequent TEL/TEL Supplement files, at six month intervals, will have a smaller number of new members. To manage the members that appear on the TEL and the TEL Supplement, DHCS is considering the following parameters:

- Members may not appear on subsequent TEL/TEL Supplement files for an MCP because:
    - The member is no longer Medi-Cal eligible in MEDS
    - The member has changed MCPs
    - The member may not meet the disease identification or SPA eligibility requirements for chronic condition criteria
- Members may move from the TEL to the TEL Supplement and from the TEL Supplement to the TEL

TEL and SPA Assignment

DHCS is required to provide separate reporting to CMS for the HHP SMI SPA and the HHP Physical Health\SUD SPA. This requirement is reflected in the HHP implementation schedule. The TEL/TEL Supplement process includes all SPA-defined chronic conditions in the initial steps. In order to support the implementation schedule and MCP requests for additional TEL-related information, the initial TEL/TEL Supplement in each geographic implementation group will include both Physical health/SUD and SMI conditions.

However, members with only SMI conditions are not eligible for the first implementation in each County. The SMI-only members on the TEL/TEL Supplement are identified when Chronic Condition Criteria #3 equals '1' and Chronic Conditions Criteria #1, #2, and #4 are all equal to '0'. MCPs will be required to separately identify HHP members between physical health\SUD and SMI on the Supplemental Payment file sent to DHCS for payment purposes (See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information).

HHP TEL/TEL Supplement – Fixed-width Record Layout v1.3

| Field Id | Field Name | Description | Length | Start | End | Data Type |
|---|---|---|---|---|---|---|
| 1 | TEL Report Date | Date of generation of the TEL and TEL Supplement (CCYYMMDD) | 8 | 1 | 8 | A |

| Field Id | Field Name | Description | Length | Start | End | Data Type |
|---|---|---|---|---|---|---|
| 2 | CIN | Client Identification Number is the unique Member ID assigned by MEDS. | 9 | 9 | 17 | A |
| 3 | Birth Date | Member's Birth date (CCYYMMDD format). | 8 | 18 | 25 | A |
| 4 | Age | Member’s Age | 3 | 26 | 28 | A |
| 5 | Member’s Last Name | Member’s Last Name | 20 | 29 | 48 | A |
| 6 | Member’s First Name | Member’s First Name. | 20 | 49 | 68 | A |
| 7 | Member’s Middle Initial | Member’s Middle Initial | 1 | 69 | 69 | A |
| 8 | Member's Gender Code | Member's Gender Code | 1 | 70 | 70 | A |
| 9 | Member's County Code | Member's County Code | 2 | 71 | 72 | A |
| 10 | Member's County Code Description | Member's County Code Description | 15 | 73 | 87 | A |
| 11 | Member's Primary Aid Code | Member's Primary Aid Code | 2 | 88 | 89 | A |
| 12 | Medicare Part A Status | Medicare Part A Status | 1 | 90 | 90 | A |
| 13 | Medicare Part B Status | Medicare Part B Status | 1 | 91 | 91 | A |
| 14 | Medicare Part D Status | Medicare Part D Status | 1 | 92 | 92 | A |
| 15 | Plan Code for Member | Plan Code for Member | 3 | 93 | 95 | A |
| 16 | Asthma Chronic Condition | Member met the HHP criteria for Asthma ('1' for yes, '0' for no). | 1 | 96 | 96 | A |
| 17 | Bipolar Chronic Condition | Member met the HHP criteria for Bipolar ('1' for yes, '0' for no). | 1 | 97 | 97 | A |
| 18 | Chronic Congestive Heart Failure (DHF) Chronic Condition | Member met the HHP criteria for Chronic Congestive Heart Failure ('1' for yes, '0' for no). | 1 | 98 | 98 | A |
| 19 | Chronic Kidney Disease Chronic Condition | Member met the HHP criteria for Chronic Kidney Disease ('1' for yes, '0' for no). | 1 | 99 | 99 | A |
| 20 | Chronic Liver Disease Chronic Condition | Member met the HHP criteria for Chronic Liver Disease ('1' for yes, '0' for no). | 1 | 100 | 100 | A |

| Field Id | Field Name | Description | Length | Start | End | Data Type |
|---|---|---|---|---|---|---|
| 21 | Coronary Artery Disease Chronic Condition | Member met the HHP criteria for Coronary Artery Disease ('1' for yes, '0' for no). | 1 | 101 | 101 | A |
| 22 | Chronic Obstructive Pulmonary Disease Chronic Condition | Member met the HHP criteria for Chronic Obstructive Pulmonary Disease ('1' for yes, '0' for no). | 1 | 102 | 102 | A |
| 23 | Dementia Chronic Condition | Member met the HHP criteria for Dementia ('1' for yes, '0' for no). | 1 | 103 | 103 | A |
| 24 | Diabetes Chronic Condition | Member met the HHP criteria for Diabetes ('1' for yes, '0' for no). | 1 | 104 | 104 | A |
| 25 | Hypertension Chronic Condition | Member met the HHP criteria for Hypertension ('1' for yes, '0' for no). | 1 | 105 | 105 | A |
| 26 | Major Depression Disorders Disease Category | Member met the HHP criteria for Major Depression Disorders ('1' for yes, '0' for no). | 1 | 106 | 106 | A |
| 27 | Psychotic Disorders Chronic Condition | Member met the HHP criteria for Psychotic Disorders ('1' for yes, '0' for no). | 1 | 107 | 107 | A |
| 28 | Filler | Filler | 1 | 108 | 108 | A |
| 29 | Traumatic Brain Injury Chronic Condition | Member met the HHP criteria for Traumatic Brain Injury ('1' for yes, '0' for no). | 1 | 109 | 109 | A |
| 30 | Filler | Filler | 2 | 110 | 111 | A |
| 31 | Chronic Condition Criteria #1 | Member met the HHP Chronic Condition Criteria #1 (At least two of the following conditions: Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, and Substance Use Disorder) ('1' for yes, '0' for no). | 1 | 112 | 112 | A |

| Field Id | Field Name | Description | Length | Start | End | Data Type |
|---|---|---|---|---|---|---|
| 32 | Chronic Condition Criteria #2 | Member met the Chronic Condition Criteria #2 (Hypertension and at least one of the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease, or Chronic Congestive Heart Failure) ('1' for yes, '0' for no). | 1 | 113 | 113 | A |
| 33 | Chronic Condition Criteria #3 | Member met Chronic Condition Criteria #3 (Any one of the following conditions: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders) ('1' for yes, '0' for no). | 1 | 114 | 114 | A |
| 34 | Chronic Condition Criteria #4 | Member met Chronic Condition Criteria #4 (Asthma) ('1' for yes, '0' for no). | 1 | 115 | 115 | A |
| 35 | Count of Chronic Condition Criteria | A count of the number of Chronic Conditions Criteria the member met. | 1 | 116 | 116 | A |
| 36 | Acuity Factor #1 | Member met acuity factor #1: three or more of the HHP eligible chronic conditions ('1' for yes, '0' for no). | 1 | 117 | 117 | A |
| 37 | Acuity Factor #2 | Member met acuity factor #2: one or more inpatient stay ('1' for yes, '0' for no). | 1 | 118 | 118 | A |
| 38 | Acuity Factor #3 | Member met acuity factor #3: three or more ED visits ('1' for yes, '0' for no). | 1 | 119 | 119 | A |
| 39 | Count of ED visits | The number of Emergency Department visits during the study period. | 3 | 120 | 122 | A |
| 40 | Latest ED visit DOS | The date of service for the most recent Emergency Department visit. | 8 | 123 | 130 | A |
| 41 | Count of Inpatient Admissions | The number of Inpatient Admissions during the study period. | 3 | 131 | 133 | A |
| 42 | Latest Inpatient Admission DOS | The date of service for the most recent Inpatient Admission. | 8 | 134 | 141 | A |
| 43 | Exclusion - Duals | The member is Dual Eligible ('1' for yes, '0' for no). | 1 | 142 | 142 | A |
| 44 | Exclusion - Hospice | The member had at least one service with one of the following revenue codes 0651, 0652, 0655, 0656, 0657, or with the following procedure code T2045 in the time period ('1' for yes, '0' for no). | 1 | 143 | 143 | A |

| Field Id | Field Name | Description | Length | Start | End | Data Type |
|---|---|---|---|---|---|---|
| 45 | Exclusion - ESRD | The member had at least one service with one of the following procedure codes in the time period, Z6004, Z6006, Z6012, Z6014, Z6016, Z6018, Z6022, Z6036, Z6038, Z6040, Z6030, 90967, 90968, 90969, 90970, 90989, 90993, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90935, 90937, 90945, 90947 ('1' for yes, '0' for no). | 1 | 144 | 144 | A |
| 46 | Exclusion - CCS | The member had at least one CCS End Date after the last month of the observation period or later ('1' for yes, '0' for no). | 1 | 145 | 145 | A |
| 47 | Exclusion - GHPP | The member had at least one GHPP End Date after the last month of the observation period or later ('1' for yes, '0' for no). | 1 | 146 | 146 | A |
| 48 | Exclusion - TCM | The member had at least one Targeted Case Management service in the time period (services where the Vendor Code was "92" or "93" ('1' for yes, '0' for no). | 1 | 147 | 147 | A |
| 49 | Exclusion - 1915c | The member met at least one of the following 1915c exclusions defined below, HIVAExcl, ALWExcl, DDExcl, IHOExcl, MSSPExcl, or PPC_Exclu ('1' for yes, '0' for no). | 1 | 148 | 148 | A |
| 50 | Exclusion - HIV/AIDS Waiver | Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver exclusion. The member had at least one service in the time period where the Provider type was "073" and Procedure Code in (90837, 90846, 90847, 90847, G0156, G0299, G0300, S5130, S5165, S5170, S9470, T2003, T2022, T2025, T2026, T2028, T2029) ('1' for yes, '0' for no). | 1 | 149 | 149 | A |
| 51 | Exclusion - Assisted Living Waiver | Assisted Living Waiver (ALW) Exclusion. The member had at least one service in the time period where the Vendor Code In ("44" or "84"), and (Provider Type was "092", "093", or "014"), and (the Category of Service was 118 or 119) ('1' for yes, '0' for no). | 1 | 150 | 150 | A |

| Field Id | Field Name | Description | Length | Start | End | Data Type |
|---|---|---|---|---|---|---|
| 52 | Exclusion - Developmental Disabilities Waiver | HCBS Waiver for Californians with Developmental Disabilities (DD) exclusion. The member had at least one service in the time period where the Vendor Code was "76" and the Procedure Code in (Z9002, Z9003, Z9004, Z9005, Z9012, Z9014, Z9015, Z9016, Z9020, Z9021, Z9022, Z9023, Z9025, Z9025, Z9026, Z9026, Z9027, Z9028, Z9029, Z9030, Z9031, Z9032, Z9034, Z9038, Z9039, Z9043, Z9046, Z9047, Z9048, Z9050, Z9056, Z9058, Z9059, Z9060, Z9061, Z9062, Z9063, Z9064, Z9065, Z9066, Z9067, Z9069, Z9072, Z9073, Z9074, Z9075, Z9076, Z9077, Z9078, Z9079, Z9101, Z9102, Z9103, Z9104, Z9105, Z9106, Z9110, Z9111, Z9112, Z9113, Z9121, Z9122, Z9123, Z9124, Z9125, Z9126, Z9200, Z9202, Z9203, Z9204, Z9205, Z9206, Z9207, Z9208, Z9302, Z9303, Z9304, Z9305, Z9306, Z9307, Z9308, Z9310, Z9311, Z9312, Z9313, Z9314 ,Z9315, Z9400, Z9401, Z9402, Z9403, Z9404, Z9405, Z9406, Z9406, Z9407, Z9408, Z9999) ('1' for yes, '0' for no). | 1 | 151 | 151 | A |
| 53 | Exclusion - IHO/HCBA Waivers | In-Home Operations Waiver (IHO) / Home and Community-Based Alternatives (HCBA) exclusion. The member had at least one service in the time period where the Vendor Code was "71" and Provider type is “014, 059, 066, 067, 069, 078, 095”) or where the Vendor Code was "89" and the Special Program Code (SPECIAL_PGM_TYPE_CD was "3" (IHO Personal Care Services (WPCS)) ('1' for yes, '0' for no). | 1 | 152 | 152 | A |

| Field Id | Field Name | Description | Length | Start | End | Data Type |
|---|---|---|---|---|---|---|
| 54 | Exclusion - MSSP Waiver | Multipurpose Senior Services Program Waiver (MSSP) exclusion. The member had at least one service in the time period where the Vendor Code was "81", the Provider Type is ‘074’, and the Procedure Code in (Z8550, Z8551, Z8552, Z8553, Z8554, Z8555, Z8556, Z8557, Z8558, Z8559, Z8560, Z8561, Z8562, Z8563, Z8564, Z8565, Z8566, Z8567, Z8568, Z8569, Z8570, Z8571, Z8572, Z8573, Z8574, Z8575, Z8576, Z8580, Z8581, Z8582, Z8583, Z8584, Z8585, Z8586, Z8587, Z8588, Z8589, Z8590, Z8591, Z8592, Z8593, Z8594, Z8595, Z8596, Z8597, Z8598, Z8599, Z8600, Z8601, Z8602, Z8603) ('1' for yes, '0' for no). | 1 | 153 | 153 | A |
| 55 | Exclusion - PPC Waiver | Pediatric Palliative Care (PPC) Waiver exclusion. During the observation period, the member in one of the following counties: Fresno, Los Angeles, Marin, Monterey, Orange, San Francisco, Santa Clara, Santa Cruz, Sonoma, or Ventura, the Provider Type is ‘014 or ‘039, the Category of Service is ‘120, and the Procedure Code is ‘G9012’ ('1' for yes, '0' for no). | 1 | 154 | 154 | A |
| 56 | Exclusion - PACE, SCAN, AHF | PACE, SCAN, and AHF exclusion. As of the last month, the member had one of the following Plan Codes: 050-065, 200-207, 601, or 915. ('1' for yes, '0' for no). | 1 | 155 | 155 | A |
| 57 | Exclusion - LTC Resident | Long Term Nursing Facility residents exclusion. As of the end of the study period the member had one of the following Long Term Care (Nursing Facility) Aid Codes: "13", "23", "53", or "63" ('1' for yes, '0' for no). | 1 | 156 | 156 | A |
| 58 | Exclusion - FFS | Fee-For-Service exclusion. As of the end of the study period the member was in Fee For Service (Plan Code 000) ('1' for yes, '0' for no). | 1 | 157 | 157 | A |
| 59 | Count of Exclusions | A count of the number of Exclusions for which the member met the requirements. | 2 | 158 | 159 | A |
| 60 | TEL Indicator | A value of "1" indicates a TEL record; a value of “0” indicates a TEL Supplement record | 1 | 160 | 160 | A |



Back to Agenda

## C. Appendix C – Training Requirements

This section outlines training that MCP and CB-CME staff who will be delivering HHP services are required to receive prior to participating in the administration of the HHP. It also includes recommendations for training CB-CME staff on several core competencies.

**Required HHP Trainings for Prior to HHP Implementation**
MCP and CB-CME staff who will be delivering HHP services are required to receive HHP-specific training prior to HHP implementation. The required training topics described below cover basic program components. DHCS provided PowerPoint training materials that MCPs can leverage for their required trainings. However, it is also acceptable for an MCP to use non-DHCS developed training materials to satisfy one, or more, of the requirements. DHCS-developed training materials are saved on both the portal and DHCS' Health Homes Program website.

MCPs must be prepared to follow the required high-level trainings with more specific HHP operational training for their staff and CB-CME staff that provide HHP services. This should include MCP-specific information on operations, workflows, how HHP intersects with MCP care coordination initiatives, data reporting, and other implementation issues. DHCS and Harbage Consulting will work with each MCP to discuss their needs and the best approach for providing the required trainings.

The required HHP training topics are:

**1. Health Homes Program Overview**
All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on the program. Required training modules shall describe the goals and scope of the HHP, team member roles and how they should work together, the services that should be provided, and how HHP intersects with other California state care coordination programs. The training shall introduce topics related to caring for the populations served under HHP, including those with chronic conditions and homeless individuals, and the impact of social determinants of health on patients.

**2. Health Action Plan, Care Coordination, and Care Transitions within the Health Homes Program**
All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on best practices for working with members and providers to design and implement the Health Action Plan, conduct care coordination activities, and support patient transitions between different levels of care.

Required training shall cover approaches and best practices for developing and implementing a Health Action Plan and providing patient-centered care, taking into account the individual's preferences, values, and unique needs. It shall also cover best practices for care management for specific chronic diseases that are prevalent in the patient population and best practices for serving the SMI population.

Staff shall be trained in best practices for coordinating care across care settings, with particular focus on medical care, behavioral health services, and services addressing social determinants of health and housing. Training shall include effective strategies for care transitions, including best practices for reducing hospital readmissions and medication errors at care transitions.

3. **Community Resources and Referrals** (required for care coordinators and housing navigators)

This training shall provide information about available community resources, how to develop relationships with community partners, and best practices for connecting members to community services. This training is required for MCP and CB-CME care coordinators and housing navigators.

MCPs are encouraged to provide additional training and/or guidance about specific local and community organizations and resources available to the CB-CME staff.

**Recommended but Optional Training for CB-CME Staff on Core Competencies**

DHCS recommends that relevant MCP and CB-CME staff receive training on the following core competencies in order to successfully implement HHP. DHCS plans to provide trainings and/or resources on these topics, which will be saved on the portal and available on-demand.

1) Special Populations (homelessness, domestic violence, SMI, etc.)

Team members should have access to training and resources specific to the patient populations they serve.

2) Social Determinants of Health

Trainings and resources related to social determinants of health should be made available for team members. Social determinants of health include gender, age, education, income and employment, social/cultural networks, housing and physical environments and other factors that impact health outcomes and access to care.

3) Motivational Interviewing

Motivational interviewing is a communication technique that seeks to elicit an individual's internal motivation to make set and accomplish positive goals. The technique uses a non-confrontational, collaborative approach to help the patient find his or her own motivation and initiate change. The patient is empowered to make personal choices, resulting in increased likelihood of compliance with care plans.

4) Trauma-informed Care

Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma. Trauma-informed care emphasizes safety (physical, psychological and emotional) for patients and providers and seeks to empower patients with self-care tools.

5) Health Literacy Assessment

Health literacy refers to a patient's capacity to find and understand health information and services in order to make informed health decisions. Assessment of patient health literacy is essential to the creation of a patient-centered care plan.

6) Information Sharing

Team members should be trained on requirements related to sharing member information and data with other entities for the purpose of care coordination. These entities include the MCP, CB-CMEs, the care team, the county, hospitals, other providers, and community-based organizations including housing organizations.

## D. Appendix D – Readiness Requirements and Checklist

### Readiness Requirements and Checklist

This checklist is not intended to be all-inclusive. Additional information as needed may be requested by the Department.

#### General Instructions

Thank you for your interest in participating in the Health Homes Program (HHP). To ensure that Medi-Cal managed care health plans (MCPs) are ready to implement the Health Homes Program, MCPs must submit the documentation listed below and attest that other program requirements have been completed. **There are multiple deadlines for submissions for each implementing MCP group. Please see Appendix I for the HHP Implementation Schedule by group. Submission deadlines for each group are as follows:**

1. **Group 1 – March 1, 2018; May 1, 2018; and November 1, 2018.**
2. **Group 2 – September 1, 2018; November 1, 2018; February 1, 2019; and May 1, 2019.**
3. **Group 3.1 – January 1, 2019; April 1, 2019; July 1, 2019; and October 1, 2019.**
4. **Group 3.2 – March 1, 2019; May 1, 2019; August 1, 2019; and November 1, 2019.**
5. **Group 4 – September 1, 2019; November 1, 2019; February 1, 2020; and May 1, 2020.**

**List of Deliverables:**

**Policies and Procedures (P&Ps) and Attestations:** Section I – HHP Infrastructure (Deliverables #1 – 3), Section II – HHP Services (Deliverables #4 – 5), Section IV – General HHP Operations (Deliverables #7 – 10 and 12), and the Attestations (Deliverable #13)

**Network:** Section III – Network (Deliverable #6.1, 6.3, 6.4, 6.5)

**SMI– MHP-MOU:** Section IV – General HHP Operations, MHP-MOU (Deliverable #11.1)

**SMI Network:** Section III – Network (Deliverables #6.2a and 6.2b)

| Group | Counties | Deliverable Due Dates | | Deliverable Approval Dates |
|---|---|---|---|---|
| Group 1 | San Francisco | **P&Ps**: | 3/1/18 | 5/1/18 |
| | | **Network**: | 5/1/18 | 6/1/18 |
| | | **SMI Deliverables**: | 11/1/18 | 12/1/18 |
| Group 2 | Riverside<br>San Bernardino | **P&Ps**: | 9/1/18 | 11/1/18 |
| | | **Network**: | 11/1/18 | 12/1/18 |
| | | **SMI MHP-MOU**: | 2/1/19 | 3/1/19 |
| | | **SMI Network:** | 5/1/19 | 6/1/19 |
| Group 3.1 | Imperial<br>Santa Clara | **P&Ps**: | 1/1/19 | 5/1/19 |
| | | **Network**: | 4/1/19 | 6/1/19 |
| | | **SMI MHP-MOU**: | 7/1/19 | 8/1/19 |
| | | **SMI Network:** | 10/1/19 | 12/1/19 |
| Group 3.2 | Alameda<br>Kern<br>Los Angeles<br>Sacramento<br>San Diego<br>Tulare | **P&Ps**: | 3/1/19 | 5/1/19 |
| | | **Network**: | 5/1/19 | 6/1/19 |
| | | **SMI MHP-MOU**: | 8/1/19 | 9/1/19 |
| | | **SMI Network:** | 11/1/19 | 12/1/19 |
| Group 4 | Orange | **P&Ps**: | 9/1/19 | 11/1/19 |
| | | **Network**: | 11/1/19 | 12/1/19 |
| | | **SMI MHP-MOU**: | 2/1/20 | 3/1/20 |
| | | **SMI Network:** | 5/1/20 | 6/1/20 |

DHCS expects the deliverables to be submitted in the form of MCP policies and procedures except for the organizational chart, assessment tool, health action plan template, network adequacy tables, and CB-CME subcontract. MCPs may develop standalone policies and procedures for the HHP and/or may incorporate HHP into existing policies and procedures.

**MCPs are to submit a separate set of deliverables for each county they are implementing HHP in. If one or several deliverables cover multiple counties, MCPs are not required to submit the deliverable for each county. However, the MCP must indicate which counties the deliverable applies to during the submission process. The network tables that MCPs submit are to be separated by county.**

**For MCPs in multiple groups, the plan should not resubmit deliverables already approved for a prior group, unless changes have been made.**

**When submitting existing policies & procedures with HHP-related revisions, please use the "track changes" function in Word, or strike-thru/underline equivalent in other applications, to show deletions and additions. Other forms of documentation are also permitted to supplement MCP policies and procedures. If single documents are used to demonstrate compliance with multiple requirements/deliverables, please provide a crosswalk with the specific location for each deliverable.**

Please see the *"Medi-Cal Health Homes Program: Program Guide"* (Program *Guide)* for Health Home Program requirements that correspond to this Readiness Checklist.

### Submission Requirements

MCPs should follow the regular process for submitting required deliverables to their current Contract manager(s). Please submit HHP-related deliverables to 2PlanDeliverables@dhcs.ca.gov and copy the HHP mailbox at hhp@dhcs.ca.gov.

For each submission, please provide the Plan's Name and the primary Contact Person's name and telephone number.

In addition, when submitting, please use the following email subject line and file naming conventions:

- In the subject line of the email, please note that these are HHP Deliverables by using the following subject line convention:
  "HHP Deliverable 1"; "HHP Deliverables 2 and 3"; etc.

- Please use the following file naming convention:
  [plan name and deliverable number]

The Contact Person is responsible for ensuring that all documentation and attestations are accurate. Questions may be directed to hhp@dhcs.ca.gov. DHCS will provide additional information as it becomes available, and may request additional information at a later date.

## I. HHP Infrastructure

### 1. Organizational Model:

1.1 Submit MCP's policies and procedures describing the HHP infrastructure, the roles and division of labor between the MCP and Community-Based Care Management Entities (CB-CMEs), and whether the MCP delegates any responsibilities to other entities.

1.2 Organizational chart illustrating the HHP infrastructure.

## 2. Staffing:

2.1 Submit MCP's policies and procedures describing the staffing plan for MCP and CB-CMEs, including care coordinators, community health workers, and housing navigator(s). The care coordinator ratio requirements are included in the Program Guide; however, if an MCP is interested in using a staffing model that de-emphasizes the care coordinator and instead emphasizes the roles of other team members, please describe the model here and DHCS will consider how to handle the care coordinator ratio.

The participation of community health workers in appropriate roles is recommended but not required.

2.2 Job descriptions for care coordination staff, including MCP and CB-CME staff, as appropriate.

## 3. Health Information Technology/Data and Information Sharing:

3.1 Submit MCP's policies and procedures describing how information is shared among the entire care team (including the member, CB-CME, and MCP), including whether EHR/HIT/HIE, or other methods, are used regarding the following activities:

a. Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management – standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement. Include other methods if electronic means of collection are not used.

b. Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.
   - Telehealth services including remote patient monitoring.

c. Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER. Include other methods if an electronic process is not used.

- Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR. Include other methods if electronic sharing is not used.
- Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.

d. Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.

e. Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.
   - Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used.

## II. HHP Services

### 4. Care Management:

5.1 Submit the assessment template or tool reflective of HHP-required elements such as housing instability, palliative care, and trauma-informed care.

5.2 Submit the Health Action Plan (HAP) template.

5.3 Submit MCP's policies and procedures for conducting care management, including how the MCP, in conjunction with contracted CB-CME, will:
- Develop and implement an HHP member assessment and HAP requirements and process, with enrollee and caregiver participation;
- Design the multi-disciplinary care team composition and process;
- Manage the communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; and
- Maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.
- Maintain a process for referring to other agencies, such as long term services and supports (LTSS) or behavioral health agencies, as appropriate.
- Disenroll members from HHP who no longer qualify for or require HHP services.

### 5. Care Transitions:

5.1 Submit MCP's policies and procedures for conducting care transitions, including discharge-planning workflows.

# III. HHP Network

## 6. MCP Duties/Responsibilities - Health Homes Program Network

6.1 Physical Conditions and SUD implementation

Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected enrollment and capacity as of the program launch date and as of the last day of each quarter in the first year for the Physical Chronic Conditions/SUD implementation. "Projected capacity" is the maximum caseload of the MCP's Physical Chronic Conditions/SUD HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of Physical Chronic Conditions/SUD HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable is due as a part of the Network Deliverables submission.

Please provide expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

| **Plan:** | | **CB-CME Network Enrollment and Capacity Table – Physical Conditions and SUD** | | | | | | | | | | **County:** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CB-CME Name** | **CB-CME NPI #** | **Estimates by CB-CME** | | | | | | | | | | **Expected Contract Effective Date** |
| | | **(Launch Date) Estimated HHP:** | | **(Last Day of Q1) Estimated HHP:** | | **(Last Day of Q2) Estimated HHP:** | | **(Last Day of Q3) Estimated HHP:** | | **(Last Day of Q4) Estimated HHP:** | | |
| | | **Enrollment** | **Capacity** | **Enrollment** | **Capacity** | **Enrollment** | **Capacity** | **Enrollment** | **Capacity** | **Enrollment** | **Capacity** | |
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*If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.*

Note: A separate DMHC network review specific to HHP will not be conducted; however, DMHC will continue to conduct regular Knox-Keene Act required network reviews through DMHC established processes.

6.2 SMI Implementation

a. Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected HHP enrollment and capacity for these CB-CMEs as of the program launch date and as of the last day of each quarter in the first year for the SMI implementation. "Projected capacity" is the maximum caseload of the MCP's SMI HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of SMI HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable update is due as a part of the SMI Deliverables submission.

Please provide the expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

| Plan: | | CB-CME Network Enrollment and Capacity Table – SMI | | | | | | | | County: | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CB-CME Name | CB-CME NPI # | Estimates by CB-CME | | | | | | | | | | Expected Contract Effective Date |
| | | (Launch Date) Estimated HHP: | | (Last Day of Q1) Estimated HHP: | | (Last Day of Q2) Estimated HHP: | | (Last Day of Q3) Estimated HHP: | | (Last Day of Q4) Estimated HHP: | | |
| | | Enrollment | Capacity | Enrollment | Capacity | Enrollment | Capacity | Enrollment | Capacity | Enrollment | Capacity | |
| | | | | | | | | | | | | |
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*If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.*

b. Provide a description of how behavioral health providers are incorporated into the HHP service delivery model. This deliverable is due as a part of the SMI Deliverables submission.

6.3 If applicable, provide any MCP-specific CB-CME qualifications (beyond the CB-CME qualifications listed in section V.B, CB-CME Qualifications ) that the MCP requires for the CB-CME to contract for HHP Services. This deliverable is due as a part of the Network Deliverables submission.

6.4 Submit CB-CME oversight policies and procedures, including monitoring, corrective action, progressive consequences for continued non-compliance, auditing care coordination conducted by CB-CMEs. This deliverable is due as part of the Network Deliverables Submission.

6.5 Submit CB-CME subcontract boilerplate that complies with the DHCS MCP contract requirements and includes: 1) Business Associate Agreement that allows for information and data sharing between MCP and CB-CME, 2) CB-CME to provide services in accordance with requirements in this Program Guide, and 3) CB-CME to complete DHCS/MCP required training. **If submitting prior DHCS approved subcontract boilerplate with HHP-related revisions, please use the "track changes" function in Word, or the "strike-through/underline" equivalent in other applications, to show deletions and additions.** This deliverable is due as part of the Network Deliverables Submission.

Note: MCP must have DHCS-approved subcontracts or subcontract amendments with a sufficient number of CB-CMEs to serve its HHP enrollees.

## IV. General HHP Operations

### 7. Non-Duplication of Care Coordination Services:

7.1 Submit MCP's policies and procedures for ensuring that members are not enrolled in another Medi-Cal care coordination program that would disqualify them from receiving HHP services (see Program Guide for requirements).

### 8/9. HHP Outreach Requirements

8.1 Member Engagement:

Submit MCP's policies and procedures that include the following:

- Protocols for a progressive outreach campaign (see Program Guide Appendix A for model outreach campaign protocols)
- Process for assisting members who require additional prompting or guidance to participate;
- Process for conducting outreach to homeless individuals;
- Process for reviewing and excluding names from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines

of having no substantial avoidable utilization **or** enrollment in another acceptable care management program – see Reporting Template-Instructions for definition);

- After people have been excluded from the TEL based on the process above, the process and criteria for identifying a "priority engagement group" or ranking process within the remaining TEL members. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for 'priority engagement' status will be at the MCP's discretion (upon approval by DHCS) with the goal of engaging and serving TEL members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

9.1 Member Notices:

All beneficiary notices to be sent by the MCP regarding the HHP should be filed for DHCS review. If the MCP is licensed by DMHC, these notices should additionally be filed with DMHC for review. DHCS is aligning with DMHC requirements regarding notice review, and DMHC requires MCPs to file all advertisements for review. All outreach materials and scripts that will be distributed should be filed prior to use by the MCP. Submission through this readiness checklist process will begin the DHCS notice review/approval process. MCPs may provide notices for DHCS review at any time prior to the member notices deliverable due date.

Note: Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. DHCS' HHP Beneficiary Toolkit is an optional resource for the MCPs for examples of 'best practice' member messaging (though the HHP Member Toolkit messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

## 10. Risk Grouping:

10.1 Submit MCP's policies and procedures for ensuring that HHP members receive the appropriate services at the appropriate intensity level, including tiering of services based on risk grouping and the associated payment structure (but not amounts). See Section V. Health Homes Program Network, G. Risk Grouping in this Program Guide for additional information.

## 11. Mental Health Services:

11.1 Signed local Mental Health Plan (MHP) Health Memorandum of Understanding (MHP-MOU) to ensure seamless access and delivery of mental health services. The MHP-MOU must be in place as of the date of implementation of HHP for members



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with SMI conditions. MCPs will develop or amend existing MOUs with county MHPs to address HHP-specific information.

DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018), including Attachment 2 of this APL, to address the HHP-specific information that MCPs must include in new, or amended, MOUs. MCP must submit the new or amended MHP-MOU by November 1, 2018 for Group 1 MCPs; February 1, 2019, for Group 2 MCPs; July 1, 2019 for Group 3.1 MCPs; and August 1, 2019 for Group 3.2 MCPs.

## 12. Housing Services:

12.1 Submit MCP's policies and procedures for providing the required housing services, including how the MCP will identify and work with community resources to ensure seamless access to delivery of housing support services. MCPs must provide housing navigation services, not just referrals to housing. (See Program Guide for requirements.)

## 13. Health Homes Program Readiness – Attestations

*The operational process attestations below reflect the MCP's commitment to being fully prepared as of the HHP implementation date. Please check the boxes and sign below to indicate MCP's compliance with the following readiness requirements for the Health Homes Program.*

☐ **F. Training**: Attest (check the box) that the MCP and CB-CMEs will complete all DHCS-required HHP training prior to participating in the administration of the HHP, as outlined in the *Program Guide*.

☐ **G. Service Directory**: Attest (check the box) that the MCP or the CB-CME(s) has completed and will maintain a directory of community services and supports that is available to all CB-CMEs and care coordinators.

☐ **H. Quality of Care**: Attest (check the box) that the MCP has incorporated HHP into existing quality management processes.

☐ **I. Cultural Competency, Educational and Health Literacy**: Attest (check the box) that the MCP has incorporated HHP into existing Policies & Procedures on these topics.

☐ **J. Member Communication**: Attest (check the box) that the MCP has incorporated HHP into existing policies regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers), into account in communicating with enrollee.

☐ **K. Members Experiencing Homelessness**: Attest (check the box) that the MCP has incorporated HHP-specific information into the appropriate Policies & Procedures for homeless members, including special service requirements, provider criteria (to comply with homeless experience requirements per AB 361), and engagement processes.

☐ **L. Reporting**: Attest (check the box) that the MCP has the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP service encounters for services provided by the MCP and the CB-CMEs (see *Program Guide* and *reporting template* for reporting requirements).

☐ **M. Service Requirements**: Attest (check the box) that the MCP will comply with all the with all service requirements, including for the six core services and the additional service requirements listed in the Program Guide.

I am authorized to make this attestation on behalf of:

| | |
|---|---|
| ______________________________ | ______________________________ |
| Managed Care Plan | Signature of Authorized Representative |
| ______________________________ | ______________________________ |
| Date | Name of Authorized Representative |
| | ______________________________ |
| | Title of Authorized Representative |

## E. Appendix E – Service Codes for the Health Homes Program

DHCS has defined the ACA 2703 Health Home Program (HHP) service codes for use on encounters and for other purposes. The HHP is required to utilize HIPAA-compliant coding standards. This revised coding scheme incorporates comments received on the initial proposed coding scheme released in October 2016. The HHP team and the DHCS Office of HIPAA Compliance identified CPT and HCPCS codes for HHP. In addition, the HHP team investigated other potential codes and reviewed codes used by a few other states.

DHCS initially selected HCPCS code G0506 for HHP, however it was found to conflict with National Correct Coding Initiative rules. DHCS instead adopted HCPCS code G9008 effective as of 10/1/2018. The definition of G9008 is as follows: Coordinated care fee, physician coordinated care oversight services. G9008 along with seven different modifiers are listed in the table below for the HHP services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Supports). This coding scheme uses HIPAA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other HHP services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The HHP coding scheme is as follows:

| HHP Service | HCPCS Code | Modifier | Units of Service (UOS) |
|---|---|---|---|
| In-Person: Provided by Clinical Staff | G9008 | U1 | 15 minutes equals 1 UOS; Multiple UOS allowed |
| Phone/Telehealth: Provided by Clinical Staff | G9008 | U2 | 15 Minutes equals 1 UOS; Multiple UOS allowed |
| Other Health Home Services: Provided by Clinical Staff | G9008 | U3 | 15 Minutes equals 1 UOS; Multiple UOS allowed |
| In-Person: Provided by Non-Clinical Staff | G9008 | U4 | 15 Minutes equals 1 UOS; Multiple UOS allowed |
| Phone/Telehealth: Provided by Non-Clinical Staff | G9008 | U5 | 15 Minutes equals 1 UOS; Multiple UOS allowed |
| Other Health Home Services: Provided by Non-Clinical Staff | G9008 | U6 | 15 Minutes equals 1 UOS; Multiple UOS allowed |
| HHP Engagement Services | G9008 | U7 | 15 Minutes equals 1 UOS; Multiple UOS allowed |

**Telehealth and Group Visits**

Regarding the use of the HHP HCPCS code and modifiers for HHP services provided via Telehealth and group visits – specifically, if MCPs may submit HHP encounters for telehealth and group visits using the HHP HCPCS code and modifiers for HHP in-person visits and if they may be used to satisfy the in-person visit ratio requirement – DHCS offers the following clarifying guidance.

Telehealth visits generally may not be used to meet the in-person visit ratio requirement for HHP. However, on a case by case basis, if an MCP has certain circumstances that necessitate the use of a high volume of telehealth visits for HHP, and the MCP is unable to meet the HHP in-person visit requirement because of the high-volume use of telehealth, DHCS will evaluate the circumstances and may allow the MCP to utilize some telehealth visits to meet the in-person visit requirement.

DHCS expects that group visits to be primarily used for health promotion and educational purposes as opposed to one-on-one HHP care coordination. However, if there is a one-on-one in-person component to the group visit in which the provision of any of the six core HHP services are provided, this may be reported as a separate HHP in-person visit encounter.

## F. Appendix F – Evidence of Coverage Template

**Description:**

<Plan Name> covers Health Homes Program (HHP) services for Members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long term services and supports (LTSS) for Members with chronic conditions.

You may be contacted if you qualify for the program. You can also call <Plan Name>, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call <Plan Name> to find out the conditions that qualify; and
- You meet one of the following:
  - You have three or more of the HHP eligible chronic conditions
  - You stayed in the hospital in the last year
  - You visited the emergency department three or more times in the last year; or
  - You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

**Covered HHP Services:**

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers, and others, to coordinate your care. <Plan Name> provides HHP services, which include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

**Cost to Member:**

There is no cost to the Member for HHP services.

## G. Appendix G – Reporting Template Excerpt

The below is an excerpt from the complete Reporting Template that MCPs will use to submit specific required data. For descriptions of data elements, please see Reporting Template.

Note: CPB = Controlling High Blood Pressure; CDF = Screening for Clinical Depression and Follow-up Plan; SMI = Serious Mental Illness/Serious Emotional Disturbance.

**Health Home Program (HHP) Reporting Instructions**

These instructions outline the requirements, references, and headings/categories for the following reporting template: Health Home Program Reporting Template. Reporting is required per the managed care contract.

• Data must be submitted in Excel (.xlsx). Do not submit data in .pdf, .xls, .csv, .txt, or any other format than .xlsx.

• The three months of data must be combined into one figure to represent the quarter, with the exception of member level Homeless and Housing reports and annual reports.

• Each MCP must submit only one file per reporting period that includes all counties the MCP operates in. All subcontractors must be rolled up into the main MCP's data.

• MCPs will certify the HHPQuarterlyReports or data submissions using the existing monthly data certification process with its respective DHCS Contract Manager to confirm all information submitted is complete and accurate. MCP will maintain documentation supporting the reported information.

Quarterly reports are due 60 days after the end of the quarter. Annual reports are due with Q1 reports. Member-level detail Homeless/Housing reports are due semi-annually, with the Q2 and Q4 reports. When the due date falls on Saturday, Sunday or a holiday, data must be submitted by COB the business day before the due date. For reference, the calendar-year quarters are listed below:

• Q1 and Annual – January, February, and March - due May 31

• Q2 and Member-level Homeless/Housing – April, May, and June - due August 31

• Q3 – July, August, and September - due November 30

• Q4 and Member-level Homeless/Housing – October, November, and December - due February 28

Unless otherwise noted, all "days" are calendar days.

Reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). Reports must use the following file naming convention: MCP name.HHPQuarterlyReport.Year.Quarter.DueDate.xlsx

[MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.xlsx.]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181130.xls. DHCS will not acknowledge or accept any email submissions.

**All report revisions are subject to DHCS review and approval.**

• DHCS will notify MCPs if revised reports must be submitted to correct data errors such as incorrect file naming conventions, incomplete data/columns fields, incorrect data, etc.

• Revised reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov).

• Revised reports must be submitted as a complete quarterly file. Partial files without all the required information and data will be rejected and must be resubmitted. Each quarter of data must be submitted separately. MCP must include an explanation in the HHP comments tab describing the changes and the reason for revision.

• Revised reports must use the following file naming convention: MCPName.HHPQuarterlyReport.Year.QuarterNumber.DueDate.RevisionNumber.xlsx [MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.REV#.xlsx]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181230.REV1.xlsx. to your designated folder in the "DHCS-MCQMD-Data/MCP" folder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). The revised file should be submitted as a separate file.

• Final corrections to quarterly reports must occur no later than 90 days after the end of the calendar year for corrections on the previous year's quarterly reports unless the Department requests a revised file.

**Definitions:**

**CB-CME**: Community Based Care Management Entity

**HAP**: Health Action Plan

**Homeless and Chronically Homeless:** see CA Welfare & Institution Code § 14127(e)

**Housing Services**:
https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf - see "Individual Housing Transition Services" and "Individual Housing & Tenancy Sustaining Services" on pages 3-4.

For the purposes of this document, the following definitions will apply:

- **HHP Member**: a Medi-Cal beneficiary currently enrolled in a Medi-Cal Managed Care Plan and a Health Homes Program.

- **Member**: a Medi-Cal Managed Care Plan member not currently enrolled in a Health Homes Program.

- **Individual**: Medi-Cal beneficiary or other eligible person who may not be currently enrolled in a Medi-Cal Managed Care Plan or a Health Homes Program. E.g., FFS beneficiary. May also apply to person not currently enrolled in Medi-Cal.

Definitions of Exclusionary Reasons for Non-Enrollment: The following are the allowable reasons, with definitions, for which a Medi-Cal member may be excluded from, or not enrolled into, a local Health Homes Program (HHP). These definitions are used by DHCS and its HHP partners. For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage. See the definition of Targeted Engagement Process below for additional information.

I. ***Unsafe Environment***: for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ED: After reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment or deliver HHP services, such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff.

***Individual***: Member engagement/enrollment efforts, or delivery of HHP services, cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

II. ***Declined participation***: After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate in HHP.

III. ***Unsuccessful engagement***: HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self-available, or is un-cooperative. Accurate contact information is not available for the member. This occurs before enrollment.

IV. ***Well-managed***: An assessment, which may include a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.

V. ***Participation in duplicative programs or programs excluded for HHP participation due to DHCS policy***: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following:

1. Duplicative Programs

a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH)

b. Targeted Case Management (TCM) – County, not Mental Health TCM

c. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF)

2. Programs excluded by DHCS Policy

a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month.

b. Hospice

c. Fee-For-Service

VI. ***Targeted Engagement Process***: The MCPs DHCS-approved process by which MCPs identify and prioritize individuals for engagement by using DHCS-provided Targeted Engagement List (TEL) and/or MCP member data.

For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage, that is a result of the above mentioned DHCS-approved process.

| **1. Health Home Program Enrollment Reporting** | |
|---|---|
| ***Note:*** **Only report one (1) exclusionary reason per member excluded from the Program.** | |
| **Column Name** | **Explanation** |
| Plan Code - Plan Name - County (Column A) | From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county. |
| Reporting Period (Column B) | From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3. |

| | |
|---|---|
| Number MCP excluded because not eligible - well-managed (Column C) | Enter the number of members MCP excluded via the targeted engagement process during the quarter because not eligible due to MCP assessment determining well managed. The CB-CME and/or the MCP can further define, but well-managed means (a) members with HHP chronic conditions that do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation; or (b) members that are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible. |
| Number MCP excluded because declined to participate (Column D) | Enter the number of members MCP excluded via the targeted engagement process during the quarter because they declined to participate. After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate, or to continue to participate, in HHP. |
| Number MCP excluded because of unsuccessful engagement (Column E) | Enter the number of members MCP excluded via the targeted engagement process the quarter because of unsuccessful engagement. HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self available; is un-cooperative; or accurate contact information is not available for the member. This occurs before enrollment. |

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| Number MCP excluded because duplicative program (Column F) | Enter the number of members MCP excluded via the targeted engagement process during the quarter due to being in another program that provides care management services: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following:<br>1. Duplicative Programs<br>a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH)<br>b. Targeted Case Management (TCM) – County, not Mental Health TCM<br>2. Programs excluded by DHCS Policy<br>a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month.<br>b. Hospice<br>3. Additional programs the MCP determines are duplicative as described in their progressive engagement policy |
| Number MCP excluded because unsafe behavior or environment (Column G) | Enter the number of members MCP excluded via the targeted engagement process during the quarter because of an unsafe behavior or environment. Unsafe includes Environment (for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ER): after reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff; and Individual: Member engagement/enrollment efforts cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff. |

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| Number MCP excluded because not enrolled in Medi-Cal at MCP (Column H) | Enter the number of individuals MCP excluded from via the targeted engagement process list during the quarter because they are not enrolled in Medi-Cal at the Managed Care Plan. Reasons can include, but may not be limited to, the following:<br>a. Fee-For-Service<br>b. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF)<br>c. Member is deceased |
| Number externally referred & enrolled (Column I) | Enter the number of members not part of the plan's targeted engagement process, referred to the MCP, that were enrolled. The referral process is initiated by an external provider or organization when an individual is initially assessed to be a candidate for HHP and therefore is referred to the MCP for approval. Upon MCP review and evaluation, if the individual is approved for HHP and enrolled, they would be included in this measure. If they are not approved for enrollment in HHP, they would be reported in the following measure. |
| Number externally referred but excluded (Column J) | Enter the number of individuals not part of the plan's targeted engagement process, referred to the MCP, that were excluded. Exclusion reasons include reasons identified in columns C-H. Do not add these exclusions to the counts in Columns C-H. |
| Average monthly number of dedicated care coordination FTEs (Column K) | Enter the average monthly number of care coordinators for the quarter. Only count FTEs dedicated to care coordination activities. The counts are taken at a point in time, which will be the last day of each month in the quarter, and averaged across the 3 months in the quarter to get this average quarterly number. |
| **2. Health Home Program Member Activity Reporting** | |
| **Column Name** | **Explanation** |
| Plan Code - Plan Name - County (Column A) | From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county. |
| Reporting Period (Column B) | From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3. |

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| Number initial HAP completed within 90 days (Column C) | Numerator: Enter the number of HHP members that had their initial HAP completed during the quarter and the HAP was completed within 90 days of enrollment. |
| Number initial HAP completed (Column D) | Denominator: Enter the number of HHP members that had their initial HAP completed during the quarter. |

**3. Health Home Program Homeless/Housing Member Level Detail**

**Note: This tab is to be submitted semi-annually in the Q2 report and Q4 report of every year. The Q2 report (due 8/31) will include data for January through June of the current calendar year. The Q4 Report (due 2/28) will include data for July through December of the previous calendar year.**

| Column Name | Explanation |
|---|---|
| Plan Code - Plan Name - County (Column A) | From the drop down menu, select the plan code, plan name and county combination for the county and plan code the plan operates in. Report on data based on the member's assigned county. |
| Reporting Period (Column B) | From the drop down menu, select the corresponding year and semi-annual reporting period. For example, the second reporting period of 2019 will be entered as 2019 Q3-Q4. |
| Member CIN (Column C) | Enter the Member's Client Identification Number (CIN) for all members that meet Column G and/or Column I. |
| Member Last Name (Column D) | Enter the Member's Last Name. |
| Member First Name (Column E) | Enter the Member's First Name. |
| Member Date of Birth (DOB) (Column F) | Enter the Member's Date of Birth (DOB) using format MM/DD/YYYY. |
| Homeless HHP Members and HHP Members at Risk for Homelessness During This Reporting Period (Column G) | Indicate whether the HHP enrolled member met the Federal definition of Homeless or required tenancy sustaining services at any point during the reporting period. Enter "Yes" or "No." |
| Received Housing Services During This Reporting Period (Column H) | Indicate whether the HHP enrolled member received housing services at any point during the reporting period. Enter "Yes" or "No." |
| Homeless Health Homes Members In Any Enrollment Period (Column I) | Indicate whether the HHP enrolled member met the Federal definition of Homeless at any point during their enrollment in the HHP. Enter "Yes" or "No." |

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|---|---|
| HHP Members who are no longer Homeless On Last Day of This Reporting Period (Column J) | Indicate the HHP enrolled member no longer meets the Federal definition of Homeless, as of the last day of the reporting period. If the member was disenrolled during the reporting period, report as of their last date of enrollment. Enter "Yes" or "No." |
| **4. Health Home Program Network Reporting** | |
| **Column Name** | **Explanation** |
| Plan Code - Plan Name - County (Column A) | From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county. |
| Reporting Period (Column B) | From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3. |
| CB-CME NPI # (Column C) | Enter all CB-CME NPI numbers that were contracted as of the last day of the quarter. Enter each CB-CME NPI number in each county on its own row. For example, if a MCP is contracted with a CB-CME that operates in two counties, there would be two rows for that NPI with each row having a different plan code & county. DHCS assumes that all lead CB-CMEs will have a NPI or be the MCP; if a CB-CME does not have an NPI #, please reach out to DHCS for further discussion. This is a measure of the prime contract with the MCP for care management duties, not engagement subcontractors or housing subcontractors. |
| Capacity for each CB-CME (Column D) | Enter the capacity for assigned HHP members for each CB-CME contracted in each county during the quarter. If a CB-CME operates in more than one county, separate the projected capacity for each county. Capacity is defined as the number of HHP members the CB-CME will be able to serve according to the HHP service requirements including the care manager ratio and the extent the CB-CME is able to satisfy all care team requirements. The count is taken at a point in time, which will be the last day of the quarter. |
| **5. Health Home Program Annual CMS Core Measures Reporting** | |

DHCS is required to collect and report the Core Set of Health Care Quality Measures for Medicaid Health Homes Programs according to the Technical Specifications published by CMS. DHCS will continue to make the annual Technical Specification link available to the MCPs. MCPs are required to follow the technical specifications. DHCS will use the reporting template to collect measure information from the MCPs so that DHCS can perform the aggregation, weighting, and reporting required by the Technical Specifications. For additional information on the Core Measures, refer to the Technical Specifications and Resource Manual link from CMS. Approve the license agreements and download the Technical Specifications.

https://www.medicaid.gov/license-agreement.html?file=%2Fstate-resource-center%2Fmedicaid-state-technical-assistance%2Fhealth-home-information-resource-center%2Fdownloads%2FFFY-18-HH-Core-Set-Manual.pdf

Each MCP will determine its numerator, denominator, and/or rates for the required performance measure and report these results for each county. DHCS is required to report separately for each SPA, therefore, there are separate numerator, denominator, and rates columns for Chronic Conditions and SMI. The Technical Specifications measurement year and reporting year definitions are consistent with DHCS's other HEDIS oriented timelines. The Technical Specifications require reporting results when the SPA is in effect for six or more months of the measurement period. The fields in the template will be adjusted over time to align with the Technical Specifications if/when they change.

***Note:* This tab is to be submitted annually in the Q1 report (due 5/31) of every year and include data on the previous calendar year of January through December.**

| Column Name | Explanation |
|---|---|
| Plan Code - Plan Name - County (Column A) | From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county. |
| Reporting Period (Column B) | From the drop down menu, select the corresponding year for the data reported: Year. |
| Controlling high blood pressure (CBP) (Med) age 18-59 w/HTN, BP < 140/90 - numerator (Column C) | Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator |
| CBP (Med) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column D) | Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator |
| CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column E) | Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator |

| CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column F) | Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator |
|---|---|
| CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column G) | Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator |
| CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column H) | Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator |
| CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column I) | Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator |
| CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column J) | Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator |
| CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column K) | Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator |
| CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column L) | Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator |
| CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - numerator (Column M) | Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator |
| CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column N) | Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator |
| CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column O) | Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator |
| CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column P) | Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator |
| CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column Q) | Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator |
| CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column R) | Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator |
| CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column S) | Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator |
| CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column T) | Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator |
| CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column U) | Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator |

| CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column V) | Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator |
|---|---|
| CDF (MED) - Age 12-17 - numerator (Column W) | Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - numerator |
| CDF (MED) - Age 12-17 - denominator (Column X) | Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - denominator |
| CDF (MED) - Age 18-64 - numerator (Column Y) | Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - numerator |
| CDF (MED) - Age 18-64 - denominator (Column Z) | Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - denominator |
| CDF (MED) - Age 65+ - numerator (Column AA) | Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - numerator |
| CDF (MED) - Age 65+ - denominator (Column AB) | Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - denominator |
| CDF (SMI) - Age 12-17 - numerator (Column AC) | Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - numerator |
| CDF (SMI) - Age 12-17 - denominator (Column AD) | Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - denominator |
| CDF (SMI) - Age 18-64 - numerator (Column AE) | Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - numerator |
| CDF (SMI) - Age 18-64 - denominator (Column AF) | Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - denominator |
| CDF (SMI) - Age 65+ - numerator (Column AG) | Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - numerator |
| CDF (SMI) - Age 65+ - denominator (Column AH) | Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - denominator |

| 6. Health Home Program Reporting Comments | |
|---|---|
| **Column Name** | **Explanation** |
| Comments (Column A) | Enter any relevant information pertaining to the submitted report and the data it contains. |

## H. Appendix H – HHP Eligible Condition Diagnosis Codes

HHP Eligible Condition Diagnosis Codes

| |
|---|
| **Asthma** |
| J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998 |
| |
| **CAD** |
| I20.0, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.710, I25.720, I25.730, I25.750, I25.751, I25.758, I25.759, I25.760, I25.790, I25.811, I25.82, I25.83, I25.84, I25.89, I25.9, Z95.1, Z95.5, Z98.61 |
| |
| **CHF** |
| I09.81, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9 |
| |
| **COPD** |
| J41.0, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9 |
| |
| **Dementia** |
| F01.50, F01.51, F02.80, F0281, F03.90, F03.91, F04, F05, F06.8, F07.0 , F07.81 , F07.89, F09 , F48.2, G30.9 , G31.01, G31.09 , G31.1 , G31.83 , R41.81 |
| |
| **Diabetes** |
| E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, R81, Z46.81, R82.4 Z96.41 |
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| **Hypertension** |
| I10, I67.4, I11.9, I11.0, I12.9, I12.0, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, I15.2, I15.8, I15.9, N26.2, |
| |
| **Liver Disease** |
| K72.00, K74.0, K74.60, K74.69, K74.3, K74.4, K74.5, K75.81, K76.0, K76.89, K74.1, K74.2, K76.9, K75.0, K75.1, K70.41, K71.11, K72.01, K72.90, K72.91, K76.6, K76.7, K72.10, K72.11, K76.1, K76.3, K76.5, K76.81, K77, R17, R18.8, Z48.23, Z94.4 |
| |
| **TBI** |
| S01.90XA, S01.90XD, S04.011S, S04.012S, S04.019S, S04.02XS, S04.031S, S04.032S, S04.039S, S04.041S, S04.042S, S04.049S, S04.10XS, S04.11XS, S04.12XS, S04.20XS, S04.21XS, S04.22XS, S04.30XS, S04.31XS, S04.32XS, S04.40XS, S04.41XS, S04.42XS, S04.50XS, S04.51XS, S04.52XS, S04.60XS, S04.61XS, S04.62XS, S04.70XS, S04.71XS, S04.72XS, S04.811S, S04.812S, S04.819S, S04.891S, S04.892S, S04.899S, S06.0X0A, S06.0X0D, S06.0X0S, S06.0X1A, S06.0X1D, S06.0X1S, S06.0X2A, S06.0X2D, S06.0X2S, S06.0X3A, S06.0X3D, S06.0X3S, S06.0X4A, S06.0X4D, S06.0X4S, S06.0X5A, S06.0X5D, S06.0X5S, S06.0X6A, S06.0X6D, S06.0X6S, S06.0X7A, S06.0X7D, S06.0X7S, S06.0X8A, S06.0X8D, S06.0X8S, S06.0X9A, S06.0X9D, S06.0X9S, S06.1X0A, S06.1X0D, S06.1X0S, S06.1X1A, S06.1X1D, S06.1X1S, S06.1X2A, S06.1X2D, S06.1X2S, S06.1X3A, S06.1X3D, S06.1X3S, S06.1X4A, S06.1X4D, S06.1X4S, S06.1X5A, S06.1X5D, S06.1X5S, S06.1X6A, S06.1X6D, S06.1X6S, S06.1X7A, S06.1X7D, S06.1X7S, S06.1X8A, S06.1X8D, S06.1X8S, S06.1X9A, S06.1X9D, S06.1X9S, S06.2X0A, S06.2X0D, S06.2X0S, S06.2X1A, S06.2X1D, S06.2X1S, S06.2X2A, S06.2X2D, S06.2X2S, S06.2X3A, S06.2X3D, S06.2X3S, S06.2X4A, S06.2X4D, S06.2X4S, S06.2X5A, S06.2X5D, S06.2X5S, S06.2X6A, S06.2X6D, S06.2X6S, S06.2X7A, S06.2X7D, S06.2X7S, S06.2X8A, S06.2X8D, S06.2X8S, S06.2X9A, S06.2X9D, S06.2X9S, S06.300A, S06.300D, S06.300S, S06.301A, S06.301D, S06.301S, S06.302A, S06.302D, S06.302S, S06.303A, S06.303D, S06.303S, S06.304A, S06.304D, S06.304S, S06.305A, S06.305D, S06.305S, S06.306A, S06.306D, S06.306S, S06.307A, S06.307D, S06.307S, S06.308A, S06.308D, S06.308S, S06.309A, S06.309D, S06.309S, S06.310A, S06.310D, S06.310S, S06.311A, S06.311D, S06.311S, S06.312A, S06.312D, S06.312S, S06.313A, S06.313D, S06.313S, S06.314A, S06.314D, S06.314S, S06.315A, S06.315D, S06.315S, S06.316A, S06.316D, S06.316S, S06.317A, S06.317D, S06.317S, S06.318A, S06.318D, S06.318S, S06.319A, S06.319D, S06.319S, S06.320A, S06.320D, S06.320S, S06.321A, S06.321D, S06.321S, S06.322A, S06.322D, S06.322S, S06.323A, S06.323D, S06.323S, S06.324A, S06.324D, S06.324S, S06.325A, S06.325D, S06.325S, S06.326A, S06.326D, S06.326S, S06.327A, S06.327D, S06.327S, S06.328A, S06.328D, S06.328S, S06.329A, S06.329D, S06.329S, S06.330A, S06.330D, S06.330S, S06.331A, S06.331D, S06.331S, S06.332A, S06.332D, S06.332S, S06.333A, S06.333D, S06.333S, S06.334A, S06.334D, S06.334S, S06.335A, S06.335D, S06.335S, S06.336A, S06.336D, S06.336S, S06.337A, S06.337D, S06.337S, S06.338A, S06.338D, S06.338S, S06.339A, S06.339D, S06.339S, S06.340A, S06.340D, S06.340S, S06.341A, S06.341D, S06.341S, S06.342A, S06.342D, S06.342S, S06.343A, S06.343D, S06.343S, S06.344A, S06.344D, S06.344S, S06.345A, S06.345D, S06.345S, S06.346A, S06.346D, |

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| S06.346S, S06.347A, S06.347D, S06.347S, S06.348A, S06.348D, S06.348S, S06.349A, S06.349D, S06.349S, S06.350A, S06.350D, S06.350S, S06.351A, S06.351D, S06.351S, S06.352A, S06.352D, S06.352S, S06.353A, S06.353D, S06.353S, S06.354A, S06.354D, S06.354S, S06.355A, S06.355D, S06.355S, S06.356A, S06.356D, S06.356S, S06.357A, S06.357D, S06.357S, S06.358A, S06.358D, S06.358S, S06.359A, S06.359D, S06.359S, S06.360A, S06.360D, S06.360S, S06.361A, S06.361D, S06.361S, S06.362A, S06.362D, S06.362S, S06.363A, S06.363D, S06.363S, S06.364A, S06.364D, S06.364S, S06.365A, S06.365D, S06.365S, S06.366A, S06.366D, S06.366S, S06.367A, S06.367D, S06.367S, S06.368A, S06.368D, S06.368S, S06.369A, S06.369D, S06.369S, S06.370A, S06.370D, S06.370S, S06.371A, S06.371D, S06.371S, S06.372A, S06.372D, S06.372S, S06.373A, S06.373D, S06.373S, S06.374A, S06.374D, S06.374S, S06.375A, S06.375D, S06.375S, S06.376A, S06.376D, S06.376S, S06.377A, S06.377D, S06.377S, S06.378A, S06.378D, S06.378S, S06.379A, S06.379D, S06.379S, S06.380A, S06.380D, S06.380S, S06.381A, S06.381D, S06.381S, S06.382A, S06.382D, S06.382S, S06.383A, S06.383D, S06.383S, S06.384A, S06.384D, S06.384S, S06.385A, S06.385D, S06.385S, S06.386A, S06.386D, S06.386S, S06.387A, S06.387D, S06.387S, S06.388A, S06.388D, S06.388S, S06.389A, S06.389D, S06.389S, S06.4X0A, S06.4X0D, S06.4X0S, S06.4X1A, S06.4X1D, S06.4X1S, S06.4X2A, S06.4X2D, S06.4X2S, S06.4X3A, S06.4X3D, S06.4X3S, S06.4X4A, S06.4X4D, S06.4X4S, S06.4X5A, S06.4X5D, S06.4X5S, S06.4X6A, S06.4X6D, S06.4X6S, S06.4X7A, S06.4X7D, S06.4X7S, S06.4X8A, S06.4X8D, S06.4X8S, S06.4X9A, S06.4X9D, S06.4X9S, S06.5X0A, S06.5X0D, S06.5X0S, S06.5X1A, S06.5X1D, S06.5X1S, S06.5X2A, S06.5X2D, S06.5X2S, S06.5X3A, S06.5X3D, S06.5X3S, S06.5X4A, S06.5X4D, S06.5X4S, S06.5X5A, S06.5X5D, S06.5X5S, S06.5X6A, S06.5X6D, S06.5X6S, S06.5X7A, S06.5X7D, S06.5X7S, S06.5X8A, S06.5X8D, S06.5X8S, S06.5X9A, S06.5X9D, S06.5X9S, S06.6X0A, S06.6X0D, S06.6X0S, S06.6X1A, S06.6X1D, S06.6X1S, S06.6X2A, S06.6X2D, S06.6X2S, S06.6X3A, S06.6X3D, S06.6X3S, S06.6X4A, S06.6X4D, S06.6X4S, S06.6X5A, S06.6X5D, S06.6X5S, S06.6X6A, S06.6X6D, S06.6X6S, S06.6X7A, S06.6X7D, S06.6X7S, S06.6X8A, S06.6X8D, S06.6X8S, S06.6X9A, S06.6X9D, S06.6X9S, S06.810A, S06.810D, S06.810S, S06.811A, S06.811D, S06.811S, S06.812A, S06.812D, S06.812S, S06.813A, S06.813D, S06.813S, S06.814A, S06.814D, S06.814S, S06.815A, S06.815D, S06.815S, S06.816A, S06.816D, S06.816S, S06.817A, S06.817D, S06.817S, S06.818A, S06.818D, S06.818S, S06.819A, S06.819D, S06.819S, S06.820A, S06.820D, S06.820S, S06.821A, S06.821D, S06.821S, S06.822A, S06.822D, S06.822S, S06.823A, S06.823D, S06.823S, S06.824A, S06.824D, S06.824S, S06.825A, S06.825D, S06.825S, S06.826A, S06.826D, S06.826S, S06.827A, S06.827D, S06.827S, S06.828A, S06.828D, S06.828S, S06.829A, S06.829D, S06.829S, S06.890A, S06.890D, S06.890S, S06.891A, S06.891D, S06.891S, S06.892A, S06.892D, S06.892S, S06.893A, S06.893D, S06.893S, S06.894A, S06.894D, S06.894S, S06.895A, S06.895D, S06.895S, S06.896A, S06.896D, S06.896S, S06.897A, S06.897D, S06.897S, S06.898A, S06.898D, S06.898S, S06.899A, S06.899D, S06.899S, S06.9X0A, S06.9X0D, S06.9X0S, S06.9X1A, S06.9X1D, S06.9X1S, S06.9X2A, S06.9X2D, S06.9X2S, S06.9X3A, S06.9X3D, S06.9X3S, S06.9X4A, S06.9X4D, S06.9X4S, S06.9X5A, S06.9X5D, S06.9X5S, S06.9X6A, S06.9X6D, S06.9X6S, S06.9X7A, S06.9X7D, S06.9X7S, S06.9X8A, S06.9X8D, S06.9X8S, S06.9X9A, S06.9X9D, S06.9X9S, S14.0XXS, S14.101S, S14.102S, S14.103S, S14.104S, S14.105S, S14.106S, S14.107S, S14.108S, S14.109S, S14.111S, S14.112S, S14.113S, S14.114S, |

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| S14.115S, S14.116S, S14.117S, S14.118S, S14.119S, S14.121S, S14.122S, S14.123S, S14.124S, S14.125S, S14.126S, S14.127S, S14.128S, S14.129S, S14.131S, S14.132S, S14.133S, S14.134S, S14.135S, S14.136S, S14.137S, S14.138S, S14.139S, S14.141S, S14.142S, S14.143S, S14.144S, S14.145S, S14.147S, S14.148S, S14.149S, S14.151S, S14.152S, S14.153S, S14.154S, S14.155S, S14.156S, S14.157S, S14.158S, S14.159S, S14.2XXS, S14.3XXS, S14.4XXS, S14.5XXS, S14.8XXS, S14.9XXS, S24.0XXS, S24.101S, S24.102S, S24.103S, S24.104S, S24.109S, S24.111S, S24.112S, S24.113S, S24.114S, S24.119S, S24.131S, S24.132S, S24.133S, S24.134S, S24.139S, S24.141S, S24.142S, S24.144S, S24.149S, S24.151S, S24.152S, S24.153S, S24.154S, S24.159S, S24.2XXS, S24.3XXS, S24.4XXS, S24.8XXS, S24.9XXS, S34.01XS, S34.02XS, S34.101S, S34.102S, S34.103S, S34.104S, S34.105S, S34.109S, S34.111S, S34.112S, S34.113S, S34.114S, S34.115S, S34.119S, S34.121S, S34.122S, S34.123S, S34.124S, S34.125S, S34.129S, S34.131S, S34.132S, S34.139S, S34.21XS, S34.22XS, S34.3XXS, S34.4XXS, S34.5XXS, S34.6XXS, S34.8XXS, S34.9XXS, S44.00XS, S44.01XS, S44.02XS, S44.10XS, S44.12XS, S44.20XS, S44.21XS, S44.22XS, S44.30XS, S44.31XS, S44.32XS, S44.40XS, S44.41XS, S44.42XS, S44.50XS, S44.51XS, S44.52XS, S44.8X1S, S44.8X2S, S44.8X9S, S44.90XS, S44.91XS, S44.92XS, S54.00XS, S54.01XS, S54.02XS, S54.10XS, S54.11XS, S54.12XS, S54.20XS, S54.21XS, S54.22XS, S54.30XS, S54.31XS, S54.32XS, S54.8X1S, S54.8X2S, S54.8X9S, S54.90XS, S54.91XS, S54.92XS, S64.00XS, S64.01XS, S64.02XS, S64.21XS, S64.22XS, S64.30XS, S64.31XS, S64.32XS, S64.40XS, S64.490S, S64.491S, S64.492S, S64.493S, S64.494S, S64.495S, S64.496S, S64.497S, S64.498S, S64.8X1S, S64.8X2S, S64.8X9S, S64.90XS, S64.91XS, S64.92XS, S74.00XS, S74.01XS, S74.02XS, S74.10XS, S74.11XS, S74.12XS, S74.20XS, S74.21XS, S74.22XS, S74.8X1S, S74.8X2, S74.8X9S, S74.90XS, S74.91XS, S74.92XS, S84.00XS, S84.01XS, S84.02XS, S84.10XS, S84.11XS, S84.12XS, S84.20XS, S84.21XS, S84.22XS, S84.801S, S84.802S, S84.809S, S84.90XS, S84.91XS, S84.92XS, S94.00XS, S94.01XS, S94.02XS, S94.10XS, S94.11XS, S94.12XS, S94.20XS, S94.21XS, S94.22XS, S94.30XS, S94.31XS, S94.32XS, S94.8X1S, S94.8X2S, S94.8X9S, S94.90XS, S94.91XS, S94.92XS |
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| **Bipolar Disorder** |
| F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9 |
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| **Major Depressive Disorder** |
| F06.30, F06.31, F06.32, F06.33, F06.34, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39 |
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| **Psychotic Disorders** |
| F06.0, F06.2, F20.0, F20.1, F20.2, F20.3 , F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F44.89 |
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| **Alcohol Related** |
| F10.121, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, |

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| F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.921, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, G62.1, I42.6, K29.20, K29.21, K70.0, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.9 |
| |
| **Substance Related** |
| F11.121, F11.122, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.920, F12.921, F12.922, F12.929, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.920, F14.921, F14.922, F14.929, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.21, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.121, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.21, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.920, F19.921, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, T40.0X1A, T40.0X1D, T40.0X2A, T40.0X2D, T40.0X3A, T40.0X3D, T40.0X4A, T40.0X4D, T40.1X1A, T40.1X1D, T40.1X2A, T40.1X2D, T40.1X3A, T40.1X3D, T40.1X4A, T40.1X4D, T40.2X1A, T40.2X1D, T40.2X2A, T40.2X2D, T40.2X3A, T40.2X3D, T40.2X4A, T40.2X4D, T40.3X1A, T40.3X1D, T40.3X2A, T40.3X2D, T40.3X3A, T40.3X3D, T40.3X4A, T40.3X4D, T40.4X1A, T40.4X1D, |

| |
|---|
| T40.4X2A, T40.4X2D, T40.4X3A, T40.4X3D, T40.4X4A, T40.4X4D, T40.601A, T40.601D, T40.602A, T40.602D, T40.603A, T40.603D, T40.604A, T40.604D, T40.691A, T40.691D, T40.692A, T40.692D, T40.693A, T40.693D, T40.694A, T40.694D |
| |
| **Kidney Disease** |
| N18.1, N18.2, N18.3 , N18.4 , N18.5, N18.6, N18.9, Z48.22, Z49.01 , Z49.02, Z49.31 , Z49.32, Z91.15 , Z94.0 |

## I. Appendix I – HHP Implementation Schedule

### HHP Implementation Schedule

The California Department of Health Care Services (DHCS) announced that the implementation of the state's Health Homes Program (HHP) begins July 1, 2018. The counties included in each group and the phased implementation schedule are outlined in the table below:

### County Implementation Schedule

| Groups | Counties | (Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders | (Phase 2) Implementation date for members with eligible serious mental illness conditions |
|---|---|---|---|
| **Group 1** | • San Francisco | July 1, 2018 | January 1, 2019 |
| **Group 2** | • Riverside<br>• San Bernardino | January 1, 2019 | July 1, 2019 |
| **Group 3** | • Alameda<br>• Imperial<br>• Kern<br>• Los Angeles<br>• Sacramento<br>• San Diego<br>• Santa Clara<br>• Tulare | July 1, 2019 | January 1, 2020 |
| **Group 4** | • Orange | January 1, 2020 | July 1, 2020 |

## J. Appendix J – HHP Supplemental Payment File

Please refer to the DHCS' *Technical Guidance – Consolidated Supplemental Upload Process for further information.*

## K. Appendix K – Whole Person Care Pilot Interaction Guidance

**Joint Medi-Cal Managed Care Health Plan and Whole Person Care Pilot Guidance:**

Eligibility and Provision of Services in the Health Homes Program and

Whole Person Care Pilots

This notification provides DHCS policy guidance regarding the eligibility, enrollment and the provision of services for Medi-Cal beneficiaries concurrently eligible for both the Health Homes Program (HHP) and a Whole Person Care (WPC) Pilot.

Medi-Cal managed care health plans (MCPs) implementing the HHP are responsible for providing the following six core HHP services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria.

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots are administered at the local level where a county, a city and county, a health or hospital authority, or a consortium of any of the above can serve as the Lead Entity (LE). WPC eligibility is established by each Pilot.

**DHCS' guidance is that Medi-Cal beneficiaries that are eligible to receive services from both the WPC Pilot program and the HHP can be enrolled in either program or both, based on beneficiary choice**.

In most cases WPC pilots provide care coordination services that are similar to the care coordination services provided by the HHP program. If a Medi-Cal beneficiary is eligible for both WPC and HHP, the member may choose which program's care coordination services that want to receive. The member may not receive duplicative care coordination services from both WPC and HHP. If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC. The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

If the beneficiary chooses to receive care coordination services through WPC and is also interested in participating in the HHP, the beneficiary will not be able to receive any HHP services due to HHP, by default, being a program that consists of a set of 6 care-coordination services that are offered as the core benefit of the program.



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In most cases WPC pilots also provide other services that are not duplicative, or similar to, HHP care coordination services. A sobering center service is one example of a WPC service that is likely to not be duplicative of HHP services. If a member is eligible for both WPC and HHP, and the member chooses to receive care coordination services through the HHP, the member may still receive other WPC services (that are not duplicative of HHP services) through the WPC. The WPC pilot may claim reimbursement for these other services regardless of whether the beneficiary chooses to receive care coordination services through the WPC or the HHP.

Please see the following points regarding DHCS' expectations:

- All WPC LEs must ensure the non-duplication of services for their WPC-enrolled members.
- The LEs are required to check other program participation, including HHP, as a regular part of their assessments. DHCS recommends frequent communication between the LE and their local MCPs to ensure there is no duplication of services.
- The WPC "Certification of Lead Entity Reports" document has been revised to include an additional attestation stating that DHCS reserves the right to recoup payments made to LEs for services found to be duplicative.
- LEs are responsible for keeping auditable records, such as documentation of their in-person assessments of enrollee participation in other programs, which should address non-duplication of services.
- As always, DHCS reserves the right to perform an audit of LE data and MCP data.

State of California—Health and Human Services Agency

# Department of Health Care Services

JENNIFER KENT
*DIRECTOR*

EDMUND G. BROWN JR.
*GOVERNOR*

**DATE:** June 28, 2018

ALL PLAN LETTER 18-012

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

**SUBJECT:** HEALTH HOMES PROGRAM REQUIREMENTS

**PURPOSE:**
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

**BACKGROUND:**
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

**POLICY:**
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

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[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

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and guidelines. DHCS will notify MCPs whenever the Program Guide is updated, so that MCPs can obtain the latest information on HHP.

HHP MCPs must meet all program and reporting requirements specified in the Program Guide, all applicable state and federal laws and regulations, MCP contracts, and other DHCS guidance, including, but not limited to, APLs. Additionally, MCPs must communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including Community Based Care Management Entities, as well as any delegated entities and subcontractors.

MCPs are responsible for ensuring that all delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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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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*Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9*

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

| **Legal Name** | **Address** | **City** | **State** | **Zip Code** |
|---|---|---|---|---|
| AMVI Care Health Network | 600 City Parkway West, #800 | Orange | CA | 92868 |
| CHOC Physicians Network + Children's Hospital of Orange County | 1120 West La Veta Ave, Suite 450 | Orange | CA | 92868 |
| Family Choice Medical Group, Inc. | 15821 Ventura Blvd. #600 | Encino | CA | 91436 |
| Fountain Valley Regional Hospital and Medical Center | 1400 South Douglass, Suite 250 | Anaheim | CA | 92860 |
| Heritage Provider Network, Inc. | 8510 Balboa Blvd, Suite 150 | Northridge | CA | 91325 |
| Kaiser Foundation Health Plan, Inc. | 393 Walnut St | Pasadena | CA | 91188 |
| Monarch Health Plan, Inc. | 11 Technology Dr. | Irvine | CA | 92618 |
| Prospect Health Plan, Inc. | 600 City Parkway West, #800 | Orange | CA | 92868 |

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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,

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
1 8 — 0 0 4

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***

***PLAN APPROVED - ONE COPY ATTACHED***

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

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## 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.

JENNIFER KENT
*DIRECTOR*

State of California—Health and Human Services Agency
Department of Health Care Services

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.

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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Home Newsroom Archives

# 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 September 5, 2019**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**
10. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Events

**Contact**
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

**Recommended Actions**
1. Authorize the expenditure for CalOptima's participation in the following events:
   a. Up to $1,500 and staff participation at Somang Society Conference 2019 on Saturday, October 12, 2019 at Grace Ministries International in Fullerton;
   b. Up to ~~$3,000~~ $10,000 and staff participation at the Vietnamese Physician Association of Southern California (VPASC) Foundation's 2019 OC Free Health Fair on Sunday, October 27, 2019 at Freedom Hall at Mile Square Park in Fountain Valley;
   c. Up to $3,000 and staff participation at the Alzheimer's Orange County's 10th Annual Latino Conference on Saturday, November 16, 2019 at Templo Calvario Church in Santa Ana;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

*Rev. 9/5/19*

**Background**
CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

**Discussion**
The recommended events will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen relationships with our community partners, potentially increasing enrollment for these programs and increasing access to health care services for members in the Korean, Vietnamese and Latino communities.

a. **<u>Somang Society Conference 2019 in Fullerton</u>**.
Staff recommends the authorization of expenditures for participation in the Somang Society's Conference 2019. This is an educational event for Korean seniors in Los Angeles and Orange County. The program consists of 2 main seminars and 8 breakdown sessions. Topics are related to end of life issues, including Advance Healthcare Directives, Living Trust, Preplanning, Body Donation, Hospice, Alzheimer's Diseases, and Bereavement. The keynote speakers are Dr. Vincent Nguyen, Palliative Care Program Director from Hoag Hospital and Kyung Yu, a Social Worker and the End of Life Motivational Speaker from Korea.

This will be the first time CalOptima has attended this event. Over one thousand individuals are expected to attend. Staff recommends CalOptima's support for this event with a $1,500 financial commitment for 2019, which includes the following: Conference booklet program ¼ page advertising and (1) 10x10 exhibitor space. This is an educational event that will allow staff to provide outreach and education to the Korean community and serve members speaking one or more of CalOptima's threshold languages. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about all CalOptima's programs and services with this under-served and hard to reach population.

b. **<u>Vietnamese Physician Association of Southern California (VPASC) Foundation's 2019 OC Free Health Fair in Fountain Valley.</u>**
The VPASC Foundation's Free Health Fair will provide an opportunity to strengthen CalOptima's relationship with Vietnamese healthcare professionals and contracted providers, including physicians, specialists and others serving our members. The VPASC is a non-profit organization established to improve the quality of health care to the underserved communities of Orange County by providing free public education seminars and free annual health fairs. The health fair brings together hundreds of healthcare professionals including doctors, dentists, pharmacists, nurses and dental assistants to provide free medical services. These services will include flu shots, screenings for blood pressure, blood glucose, vision, hepatitis B/C, and breast and colon cancer. Dental services will include dental exams, fillings, and extractions. Volunteer physicians will be on-site to provide health education on topics such as management of coronary artery disease, hypertension, strokes, high cholesterol, diabetes and hepatitis B. The event is open to the public and all services including medical, dental and health education will be provided at no cost.

CalOptima has participated in the VPASC Foundation's Free Health Fair for the last three years: 2016 at a $2,000 sponsorship level; 2017 at a $3,000 sponsorship level; and 2018 at a $3,000 sponsorship level. Staff recommends CalOptima's support for this event with a $3,000 financial commitment for 2019, which includes the following: one (1) exhibitor table, 5'x3' CalOptima banner display, and CalOptima brochures in each attendee's gift bag. Additional marketing benefits include radio and newspaper recognition, CalOptima logo on the VPASC website, social media (Facebook, Instagram, Twitter), and e-mail blast. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's

programs and services, potentially increasing awareness of programs, and utilization of primary and preventive care services. During last year's health fair, over one thousand two hundred (1,200) individuals were served. VPASC is estimating that this year's event will serve over one thousand five hundred (1,500) hundred individuals.

c. **Alzheimer's Orange County 10th Annual Latino Conference in Santa Ana.**
The 10th Annual Alzheimer's Orange County Latino Conference is an educational event that provides information, resources and support to meet the needs of Spanish-speaking seniors and their caregivers through sharing information about Alzheimer's disease, obtaining updates on current research and providing information about aging well and disease prevention. Attendees will have access to free health screenings, health information and resources.

CalOptima has participated in the Alzheimer's Orange County Latino Conference for the past four years: 2015 at a $50 sponsorship level; 2016 at a $500 sponsorship level; 2017 at a $2,500 sponsorship level; and 2018 at a $2,500 sponsorship level. Staff recommends CalOptima's support for this event with a $3,000 financial commitment for 2019, which includes the following: Opportunity for CalOptima's Chief Executive Officer to provide a welcome presentation during the opening ceremony; acknowledgement in press releases and advertisements one month prior to the conference via radio, magazine, website and newspaper; one (1) exhibitor table; CalOptima's logo displayed at conference and event agenda; looping video acknowledgement at front entrance; CalOptima's brochure in participants' bag; lunch for two (2); and Certificate of Recognition. Employee time will be used to participate in this event. Employees will have an opportunity to promote the PACE expansion and OneCare Connect programs with seniors and caregivers in the Latino community. Over five hundred (500) participants are anticipated to attend this event.

CalOptima staff has reviewed the request and it meets the requirements for participation as established in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability; and
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations Department. The Community Relations Department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

**Fiscal Impact**
Funding for the recommended action of up to $7,500 is included as part of the Community Events budget under the CalOptima Fiscal Year 2019-20 Operating Budget approved by the CalOptima Board of Directors on June 6, 2019.

**Rationale for Recommendation**
Staff recommends approval of the recommended actions in order to support community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, promote health and wellness, and/or develop and strengthen partnerships in support of CalOptima's programs and services.

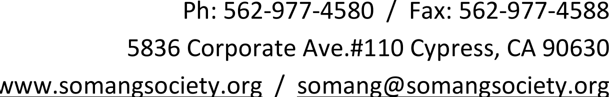
**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**
1. Contracted Entities Covered by this Recommended Board Action
2. Somang Society 2019 Conference Sponsorship Request Letter
3. VPASC 2019 OC Free Health Fair Sponsorship Request Letter
4. Alzheimer's Orange County's 10th Annual Latino Conference Sponsorship Request Letter

*/s/ Michael Schrader* *8/28/19*
**Authorized Signature** **Date**

## ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

| Name | Address | City | State | Zip Code |
|---|---|---|---|---|
| Somang Society | 5836 Corporate Ave., #110 | Cypress | CA | 90630 |
| Vietnamese Physician Association of Southern California Foundation (VPASC) | 64 Bridgeport Rd. | Newport Coast | CA | 92657 |
| Alzheimer's Orange County | 2515 McCabe Way, Ste. 200 | Irvine | CA | 92614 |




# Somang Society Conference 2019

Dear Friends,

Somang Society is a non-profit organization (501c) founded in 2007 with the slogan “Beautiful Life, Meaningful Ending”. We are actively serving Korean communities based on the values of dignity, integrity, and synergy. Our mission is to provide service and education for one’s well-being, well-aging, and well-dying.

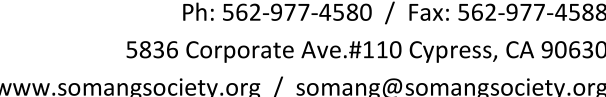
We are planning our annual forum to be held on 10/12/2019 at Grace Ministries International located in Fullerton, CA with the expected attendance of 1,000 people. The purpose of the conference is to educate and provide information regarding preparing the end of our lives with the theme, “Beautiful Life, Meaningful Ending”.

This work is only possible because of generous support from our friends and partners who deeply care about educating our community with healthcare issues. We humbly request your support once again so we can continue this work. All funds raised will be used to fund Somang Society education and programs which benefit the Korean Community in Los Angeles and Orange County with a population over 100,000. They will also be used to support Somang wells and preschool ministries in Chad, Africa.

You will find different opportunities to sponsor our conference. If you are interested in participating in our conference, please fill out the sponsorship form below and send it to us via email. Then please mail us your check to Somang Society. Please contact us before your sponsorship.

Feel free to reach out to us if you have any questions. We thank you in advance for your support!

Somang Society




# Somang Society Conference Sponsorship Form

This Sponsorship Agreement (the "Agreement") is entered into by and between

_______________________________ ("Brand") and **Somang Society** ("Organizer") for an event

known as **Somang Society Conference 2019** (the "Event").

The particulars are as follows:

**Description of Event:**

This is an educational event for Korean seniors in Los Angeles and Orange County. The program consisted of 2 main seminars and 8 breakdown sessions. Topics are related to end of life issues including Advance Healthcare Directives, Living Trust, Preplanning, Body Donation, Hospice, Alzheimer's Diseases, and Bereavement. The keynote speakers are Dr. Vincent Nguyen, Palliative Care Program Director from Hoag Hospital and Kyung Yu, a Social Worker and the End of Life Motivational Speaker from Korea.

**Date(s):** S10/12/2019 09:00 AM to 04:00 PM

**Location of Event:** Grace Ministries International at 1645 W Valencia, Fullerton, CA 92833

In consideration of the premises and the mutual covenants and conditions hereinafter set forth, and intending to be legally bound, the parties agree as follows:

## 1. Sponsorship

The parties agree that the Brand shall be designated as a presenting sponsor of the Event. The Organizer shall not offer rights of sponsorship for the Event to any entity in connection with the marketing of a brand that is in the same category as the Brand(s) without first obtaining the written consent of the company.

## 2. Term

The term of this Agreement begins on the date of execution by the last party signing the form and ends at the conclusion of the Event.

Ph: 562-977-4580 / Fax: 562-977-4588
5836 Corporate Ave.#110 Cypress, CA 90630
www.somangsociety.org / somang@somangsociety.org

## 3. Rights and Benefits

As a presenting sponsor of the Event, the following rights and benefits shall accrue to the Company according to the level of your choice:

- **Title Sponsorship:** $ 10,000
  - Special Recognition at Opening Ceremony
  - Large Banner placement in the hall
  - Conference Booklet Last page adverting in Full page
  - Booth Table (Entrance Location)
  - Press coverage through Korean newspapers
  - Company name and logo display on posters

- **Gold Sponsorship:** $ 5,000
  - Conference Booklet 1 page adverting
  - Booth Table (Entrance Location)
  - Special recognition during Closing Ceremony
  - Press coverage through Korean newspapers
  - Company name and logo display on posters

- **Silver Sponsorship:** $ 3,000
  - Conference Booklet 1/2 page adverting
  - Booth (Center Location)
  - Company name and logo display on posters

- **Bronze Sponsorship:**: $ 1,500
  - Conference Booklet Program 1/4 Page adverting
  - Booth

## 4. Sponsorship Fee

The sponsorship fee payable to Organizer by Company shall be $_______________ payable to Somang Society upon execution of this Agreement.

Name:_______________________________________Title:___________________

Signature______________________________________ Date_____ / _____/ _____

Please fill out the form and email it back to somang@somangsociety.org
Make check payable to Samang Society and mail to 17211 Valley View Ave. Cerritos, CA 90703.

# Vietnamese Physician Association of Southern California (VPASC) Foundation

**a 501(c)(3) nonprofit organization**
**Tax ID # 45-3844398**
**18080 Beach Boulevard, Suite 105, Huntington Beach, CA 92648**
**E-mail: info@vpasc.org**



## VPASC FOUNDATION BOARD

**Phuong Nguyen, M.D.**
**President**

**Dinh Vu, M.D.**
**Treasurer**

**Hao Thai, M.D.**
**Secretary**

**Monique Le, M.D.**
**Board Member**

**Luan Nguyen, M.D.**
**Board Member**

**Hung Ong, M.D.**
**Board Member**

**Timothy Thien Bui, DDS**
**Board Member**

**Patrick Kha Le, DDS**
**Board Member**


February 6, 2019

Dear Business Leaders:

*"I can do things you cannot, you can do things I cannot;*
*together we can do great things."* Mother Teresa

Thank you for giving our group this opportunity to work with you. Together we can create a healthier community.

The Vietnamese Physician Association of Southern California (VPASC) Foundation is a California 501(c)(3) nonprofit organization originally incorporated in 2011. Our primary mission is to improve the quality of health care in the underserved communities of Orange County through free public education seminars and free annual health fairs.

Each year at our VPASC Free Health Fair, our group brings together hundreds of health care professionals (doctors, dentists, pharmacists, nurses, dental assistants), students, volunteers, and community businesses to provide much-needed medical screenings, dental treatments, and preventative health education free of charge to the medically underserved population.

Last year, we renamed our VPASC Free Health Fair to the
**"OC" Free Health Fair** … the "OC" stands for "One Community."

The 2019 **"OC Free Health Fair"** Presented by VPASC Foundation will be held on
Date: Sunday October 27, 2019
Time: 9 AM – 2 PM
Location: Mile Square Park – Freedom Hall
16801 Euclid Street
Fountain Valley, CA 92708

Among the free medical services that will be available are free flu shots, blood pressure check for hypertension, blood glucose check for diabetes, vision check for glaucoma, and screenings for hepatitis B, breast cancer, and colon cancer.

Dental services will include dental exam, fillings, and extractions.

Health education lectures will be given by our volunteer physicians on important topics such as management of coronary artery disease, hypertension, strokes, high cholesterol, diabetes, and hepatitis B.

Our health fairs have always been very successful and well attended. The attendance has averaged around 1,200 patients per year for the last three years. This year, we hope to increase the attendance to 1,500 patients.

**As always, our health fair is free and open to the public.**

These public service activities are made possible only by the generous donation, sponsorship, and support of distinguished businesses in the community such as yours.

We hope that you are as passionate about bringing medical health services to the community as we are. We would appreciate if your institution will help us fund the 2019 "OC" Free Health Fair … the "OC" stands for "One Community."

Attached you will find the preliminary health fair flyer and the sponsorship level proposal.

We thank you for your time and consideration.

Sincerely,

Phuong Trang Cao, PharmD
Chair of Health Fair Committee
VPASC Foundation
Cell: (714) 206-8226

Luan Nguyen, M.D.
President
VPASC
Cell: (714) 548-5337

## TITLE SPONSORSHIP $ 20,000

**The ONLY Sponsor Name/Logo on 6 Major Banners (8' x 4.5') posted around Little Saigon**
**The ONLY Name/Logo display at the CENTER of all Health Fair Flyers**
**The ONLY Sponsor allowed to Cut Ribbon and Speak at Opening Ceremony**
**The ONLY Sponsor Name/Logo on Volunteer T-shirt**
**Television/Radio/Newspaper recognition as EXCLUSIVE TITLE SPONSOR**
**1 Display Table/Booth AT ENTRANCE of Health Fair / 1 Sponsor Banner (up to 12' x 3') display inside site**
**Business cards/brochures in attendee gift bag**
**Email Blast / Website / Social Media (FaceBook/Instagram/Twitter)**

## PLATINUM SPONSORSHIP $ 5,000

**Name on the bottom section of all Health Fair Flyers**
**Television/Radio/Newspaper Recognition**
**1 Display Table/Booth at site of Health Fair / 1 Sponsor Banner (up to 8' x 3') display inside site**
**Business cards/brochures in attendee gift bag**
**Email Blast / Website / Social Media (FaceBook/Instagram/Twitter)**

## DIAMOND SPONSORSHIP $ 3,000

**Name on the bottom section of all Health Fair Flyers**
**Radio/Newspaper Recognition**
**1 Display Table/Booth at site of Health Fair / 1 Sponsor Banner (up to 5' x 3') display inside site**
**Business cards/brochures in attendee gift bag**
**Email Blast / Website / Social Media (FaceBook/Instagram/Twitter)**

## BOOTH PARTICIPATION $ 1,500

**1 Display Table/Booth at site of Health Fair**
**Blast / Website / Social Media (FaceBook/Instagram/Twitter)**

**Sponsors provide own banners, business cards, and brochures to VPASC by October 11, 2019.**

**Please make checks payable to: VPASC Foundation - 501(c)3 - Tax ID#: 45-3844398**

*Thank you for your time and generosity.*

**Alzheimer's | ORANGE COUNTY**

July 8, 2019

To whom it may concern,

For individuals suffering from chronic health conditions, getting quality healthcare is much more than just a visit to the doctor or simply taking medication, it is also having access to education and resources needed to deal with the disease on a daily basis. This is especially true with senior patients who are suffering with Alzheimer's disease and who must often rely completely on their family members to take care of them. These caregivers can often feel very isolated as they struggle with meeting the overwhelming needs of their loved one inflicted with the disease, and at the same time meet their financial and personal responsibilities for themselves and others in their family. This can place a heavy burden on any family, but particularly challenging to those with limited financial, education and other social service resources.

The Alzheimer's Orange County Latino Outreach program has always believed that education and support from the community is the key to addressing this problem. That is why in addition to providing ongoing education and support to families for the past 8 years, this program has partnered with numerous community organizations to join forces and meet the needs of the Spanish speaking community with an annual conference.**This year we will be celebrating our 10th year anniversary; we could not have come this far without the loyal support of your organization. We invite you to join us on Saturday November 16, 2019 at Templo Calvario Church located in Santa Ana, California from 7:30 a.m. to 2:00 p.m.** This one day conference is free to the public and is an opportunity for caregivers and families who want to learn more about Alzheimer's disease to get updates about current research, as well as receiving practical information about aging well and disease prevention. The conference attendees will also have access to free health screenings, health information and resources, as well as entertainment and prizes. Each year this conference continues to grow. **In the past 9 years over 3.000 people have benefited from this event.**

This year Alzheimer's Orange County is proud to announce that we are expecting 400 people to attend the conference. However, this conference was only able to become what it is today because of corporate and community sponsors. By participating in and supporting this year's annual conference, you or your organization will enable Alzheimer's Orange County to continue the good work of the Latino Outreach Program. Sponsor recognition is outlined in the material provided.

Thank you for your kind consideration of this request. If you need further information, please contact Norma Castellano at (949) 757-3755 or by email norma castellano@alzoc.org.

Most Sincerely,

Norma Castellano
Multicultural Program Coordinator

Rama Meka
Conference Volunteer Committee Member

Alzheimer's Orange County
Tax ID # 95-3702013

Alzheimer's | ORANGE COUNTY

# 10th Annual Alzheimer's Latino Conference Sponsorship Levels

**Platinium Sponsor - $3000**

- Opportunity to give a welcome presentation to participants on behalf of the corporation during opening ceremony
- Acknowledgement in press releases and advertisements 1 month prior to conference (radio, magazine, website, and newspaper)
- Corporate logo prominently placed around conference and on the agenda
- Corporate logo placed in looping video acknowledgments at the front entrance
- Information in goody bag
- Opportunity for a table at the information fair with corporate signage
- Lunch for 2
- Certificate of recognition

**Diamont Sponsor- $2000**

- Recognition at the event during opening ceremonies
- Acknowledgement in press releases and advertisements 1 month prior to conference (radio, magazine, website, and newspaper)
- Corporate logo prominently placed around conference and on the agenda
- Corporate logo placed in looping video acknowledgments at the front entrance
- Information in goody bag
- Opportunity for a table at the information fair with corporate signage
- Lunch for 2
- Certificate of recognition

**Gold - $1500**

- Recognition at the event during opening ceremonies
- Corporate logo placed around conference and on the agenda
- Information in goody bag
- Opportunity for a table at the information fair with corporate signage
- Lunch for 2
- Certificate of recognition

**Silver Sponsorship for Non-Profit Organizations - $100**

- Information in goody bag
- Opportunity for a table at the information fair with corporate signage
- Lunch for 2
- Certificate of recognition

*Continued to a Future Meeting*

## CalOptima Board Action Agenda Referral

**Action To Be Taken September 5, 2019**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**

11. 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 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).

**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.

**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<br>  ○ Families Together of Orange County, Korean Community Services, North Orange County Regional Health Foundation, Serve the People, and Southland Integrated Services<br>• Adds a new provider for dental services, as one of these clinics does not provide dental services<br>  ○ The other four clinics provide dental services at their fixed sites<br>• Will serve six school districts | • Enhancing four mobile units and a mini clinic to ramp-up restorative care (e.g., staff, equipment, supplies, outreach and engagement materials)<br>• Will increase access to preventive and restorative care<br>• Will serve 10 school districts |

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| | Coalition of Orange County Community Health Centers (Coalition) | Healthy Smiles for Kids of Orange County (Healthy Smiles) |
|---|---|---|
| **Use of Funds (examples)** | • Purchase and equipping mobile unit<br>• Consulting (coordinating with clinics for HRSA change in scope/licensing and curriculum development)<br>• Staff<br>• Supplies (e.g., dental, oral hygiene kits) | • Restorative and portable equipment expansion<br>• Recruitment and training for 20 new clinical positions, as well as portion (less than 20%) salary and other costs<br>• Service fees (contract reviews and move costs for mini clinic)<br>• 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<br>  ○ First year focusing on infrastructure development (e.g., acquisition of three chair mobile unit, staffing, etc.<br>  ○ Services delivery begins in Year 2 | • During the one-year term: Will serve 13,500 additional CalOptima members<br>  ○ Service delivery begins within three-months of funding |

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 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 to support purchase and equipping two three-chair mobile clinics. As a result, the initial proposed funding amount could be significantly reduced, 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.

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 6/7to 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 over 31,000 sealants applied.

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**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. Entities Covered by this Board Action
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

*/s/ Michael Schrader* *8/28/19*
**Authorized Signature** **Date**

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)<br>• Korean Community Services (FQHC Look-Alike in Buena Park)<br>• North Orange County Regional Health Foundation (FQHC Look-Alike in Fullerton)<br>• Serve the People (FQHC in Santa Ana)<br>• Southland Integrated Services (FQHC in Garden Grove)<br>• Anaheim Union High School District<br>• Boys and Girls Clubs<br>• Buena Park School District<br>• Centralia School District<br>• Fullerton School District<br>• Hands Together<br>• KidWorks<br>• Lighthouse Community Centers<br>• Project Access<br>• Rancho Santiago Community College District<br>• Santa Ana Unified School District<br>• The Cambodian Family<br>• 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<br>• 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<br>• Unsure of how safety net clinic/co-lead would maintain staffing<br><br>Site Visit:<br>• The collaborative clinics are very passionate of the work<br>• One of the five clinics currently does no have a fixed site dental program, they will need to build out a program<br>• For all sites a mobile unit will need to be built out to implemented the mobile dental program<br>• 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<br>• Smile Clinic at CHOC Children’s<br>• Garden Grove Unified School District<br>• Santa Ana Unified School District<br>• Westminster Unified School District<br>• Anaheim Unified School District<br>• Buena Park Unified School District<br>• La Palma Unified School District<br>• Tustin Unified School District<br>• Fountain Valley Unified School District<br>• Stanton Unified School District<br>• Placentia Unified School District<br>• Fullerton Unified School District<br>• 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<br>• Organization has deep knowledge and experience providing comprehensive dental services and link member back to a dental home<br>• Mobile unit can be up and running in three months for immediate impact<br><br>Site Visit:<br>• Well established organization and supportive leadership<br>• Presentation was well organized<br>• Goals and objective are well understood |
| | | | | | | | | | | |

*Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 11*

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

**Board of Directors Meeting**

**September 5, 2019**

**Candice Gomez**

**Executive Director, Program Implementation**

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# Background

- Intergovernmental Transfer (IGT) funds are to be used to provide enhanced/additional benefits to existing Medi-Cal members
- CalOptima Board of Directors approved IGT 5
  - April 2016 Strengthening the Safety Net priority area
  - June 2018 release of Requests for Information to support development of scopes of work for Requests for Proposals (RFP)
  - December 2018 approved allocation of $1 million for and release of RFP to support Access to Children’s Dental Services within the Strengthening the Safety Net priority area

# 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

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# 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%)

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# RFP Evaluation Process – Site Visit

- Site visits conducted with top two applicants
  - ➢ Better understand the organization and its current programs
  - ➢ Learn more about the proposed project and how it fits with the organizations mission
  - ➢ Identify the organization's leadership capacity and skills to effectively provide the proposed services
- After site visit, consider strengths and weaknesses that may support or suggest concerns with awarding a grant
  - ➢ Impression of organizations
  - ➢ Proposed project
- Proposals were not rescored after site visits

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# Evaluation Scores for Top Two Applicants

| | 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 |

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# Considerations

- Ad Hoc discussed two highest scoring applications
  - Some focus areas included
    - Intended use of funds
    - Service areas
    - Ramp up time for service delivery
    - Number of members served during grant term
    - Sustainability

- Potential to split award amount
  - Based on feedback from applicants, each request is scalable
    - Coalition of Orange County Community Clinics: Recently received funding from another source for vehicles permits reduction in funding without reducing other deliverables
    - Healthy Smiles for Kids of Orange County: Reduced award would result in proportionate reduction in children served

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# Recommended Board Actions

- Approve the recommended allocation of IGT 5 funds in the amount of $1.0 million for Access to Children’s Dental Services in a community grant; and,
- Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contracts with the recommended community grantee.

# 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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# 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:<br><br>-Board/Advisory Members Roster<br>-IRS Determination Letter (if applicable)<br>-Form 990 (if applicable)<br>-Most Recent Audited Financial Statements<br>-Completed IRS W-9 Form<br>-Project Staffing Plan<br>-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.

**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.

| # | 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.

**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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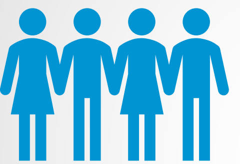
# More Engaging: Members



## Focus Groups

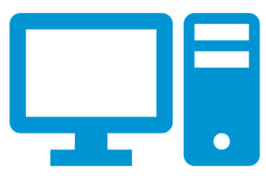
- 31 face-to-face meetings in the community
- 353 members

## 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

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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

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

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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.

**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

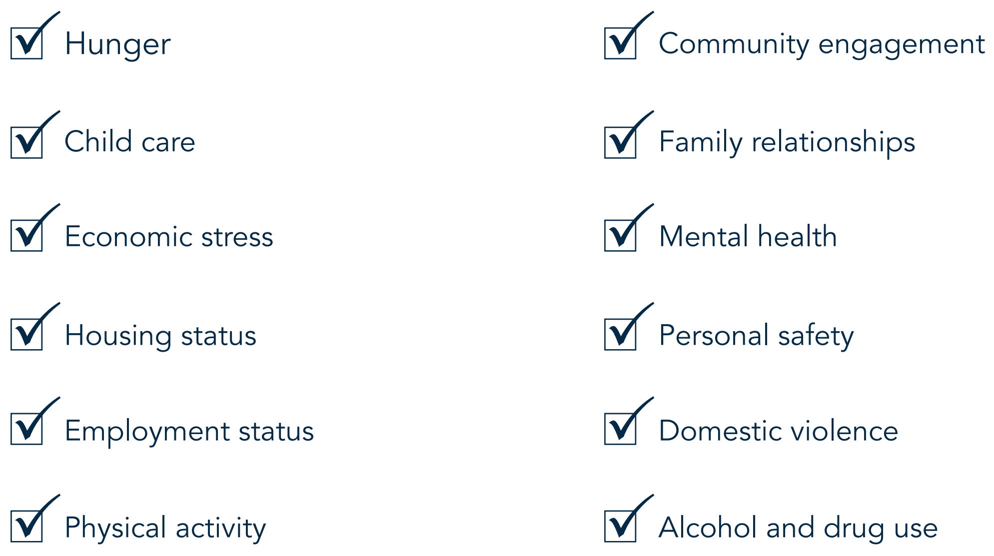
## More Comprehensive

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:




*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)

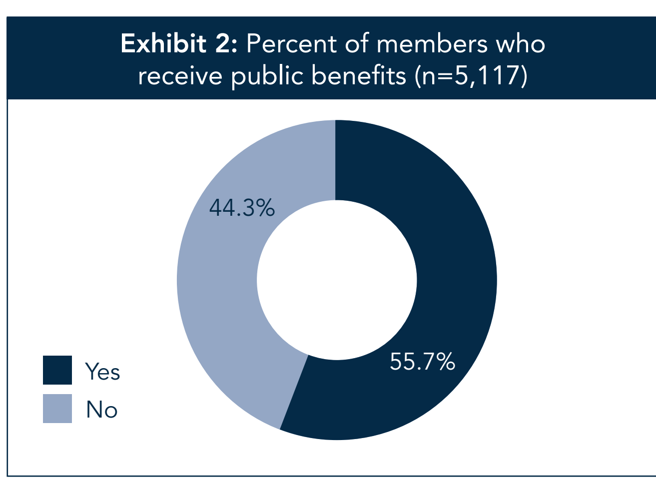
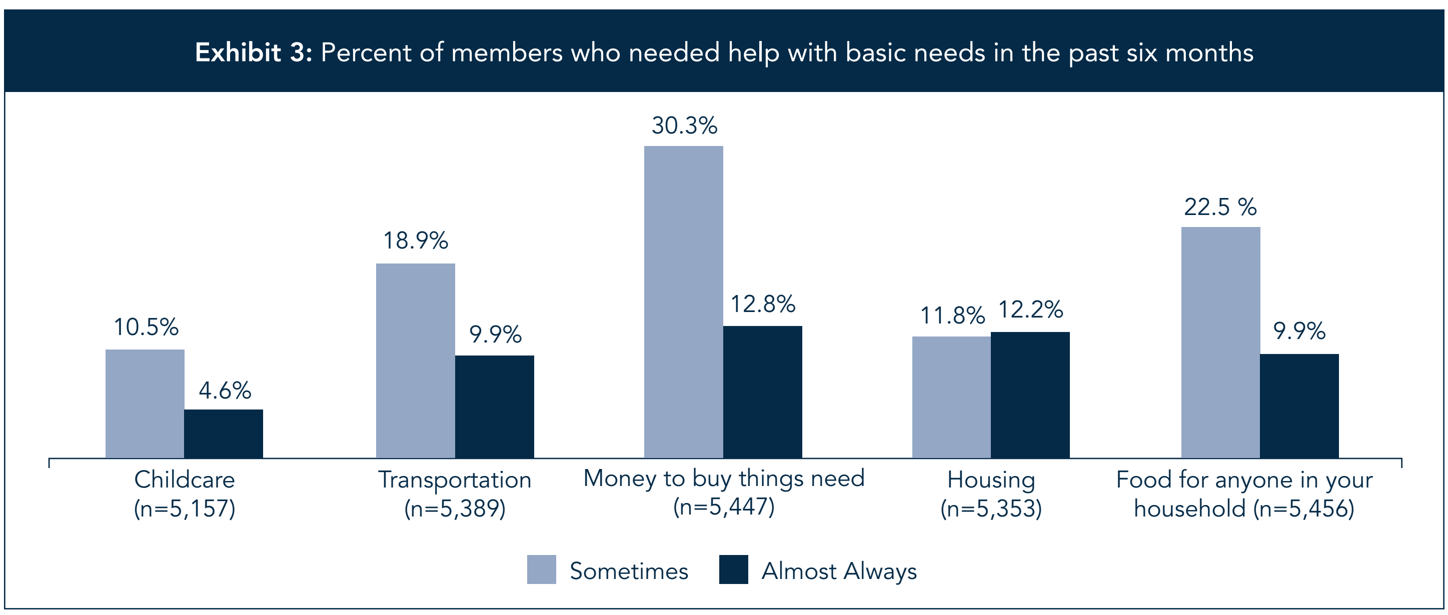
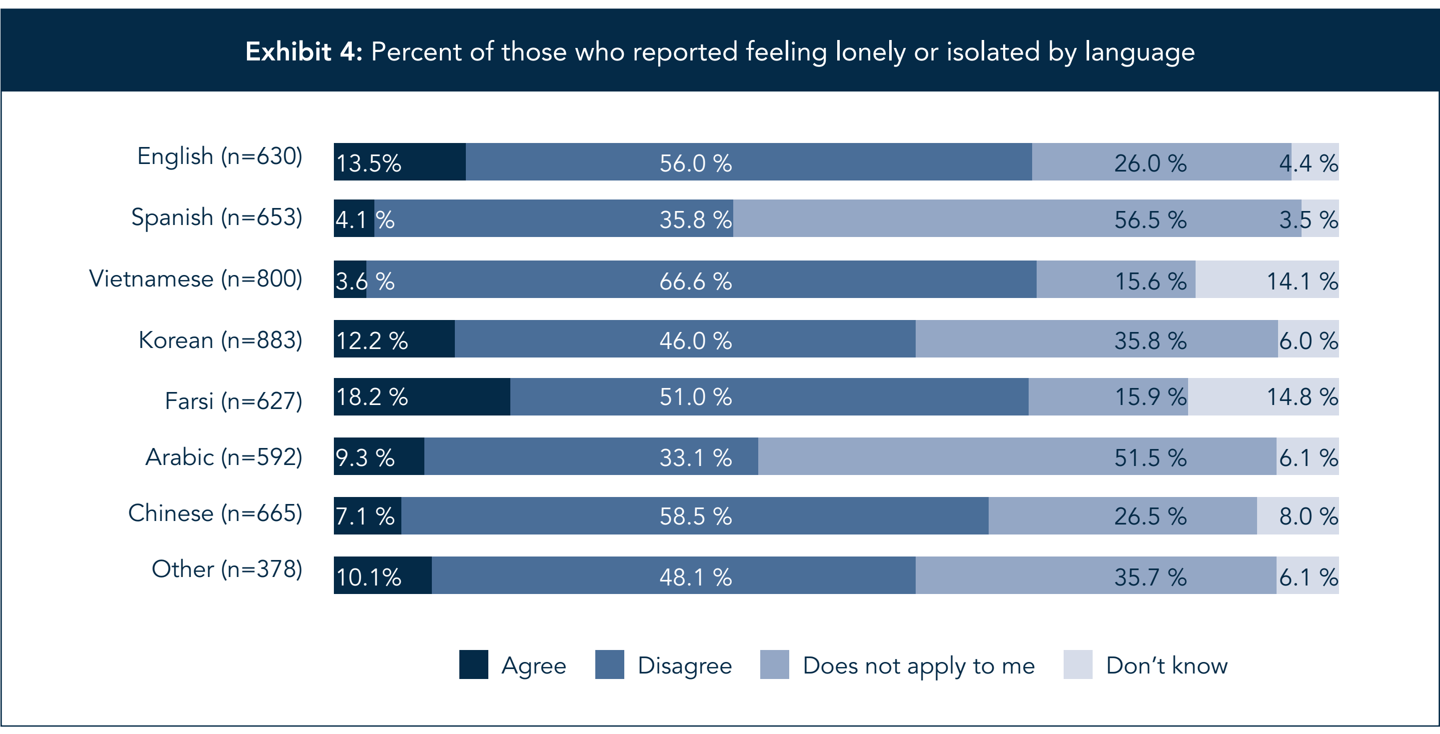



**Exhibit 3:** Percent of members who needed help with basic needs in the past six months



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).




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)

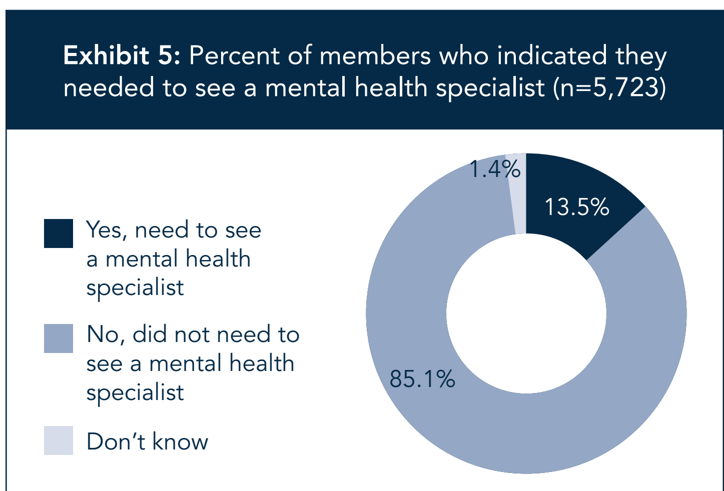
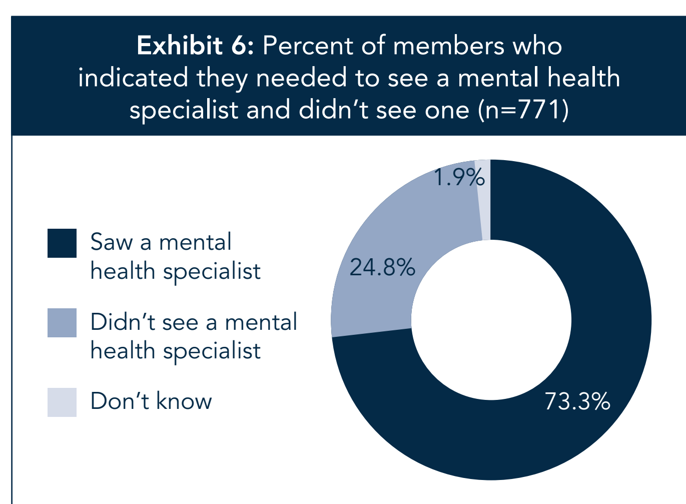
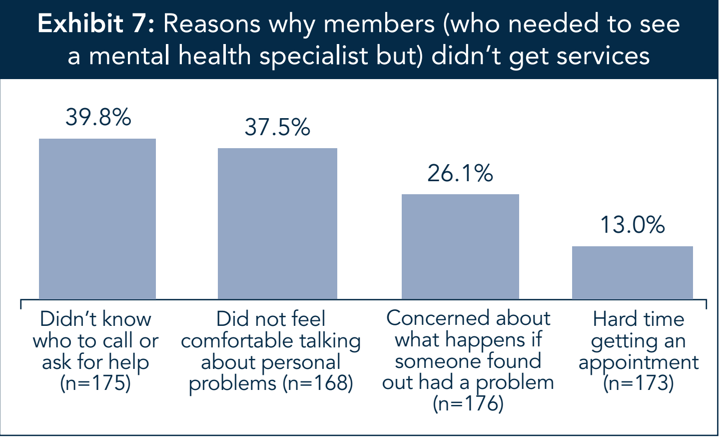



**Exhibit 6:** Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)




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)

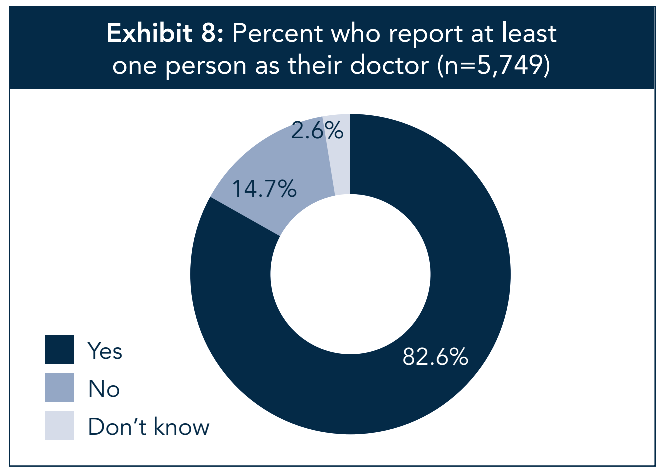
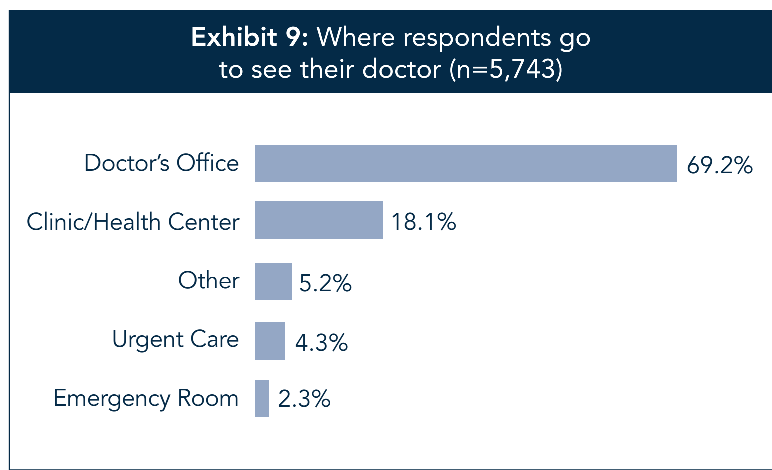



**Exhibit 9:** Where respondents go to see their doctor (n=5,743)

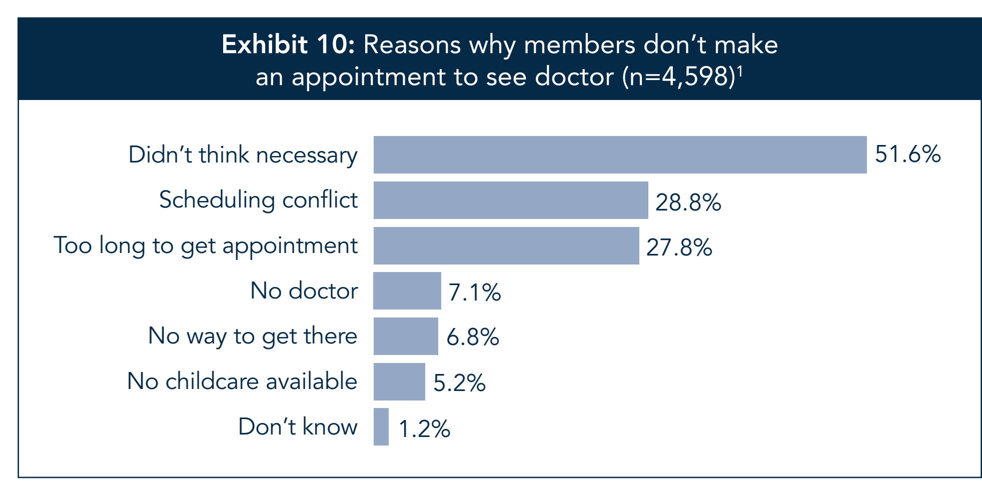



Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited 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)

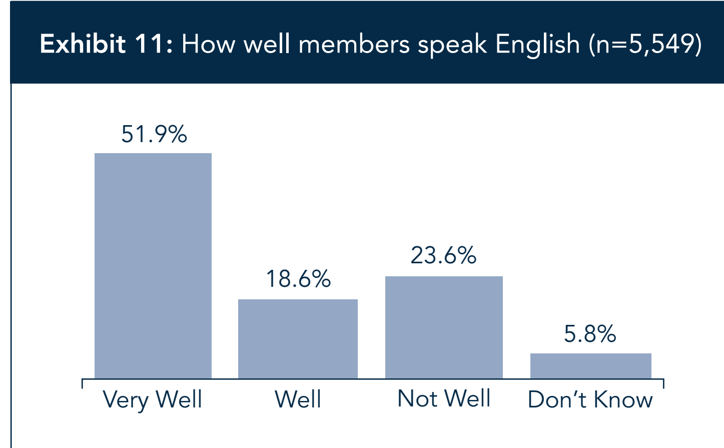
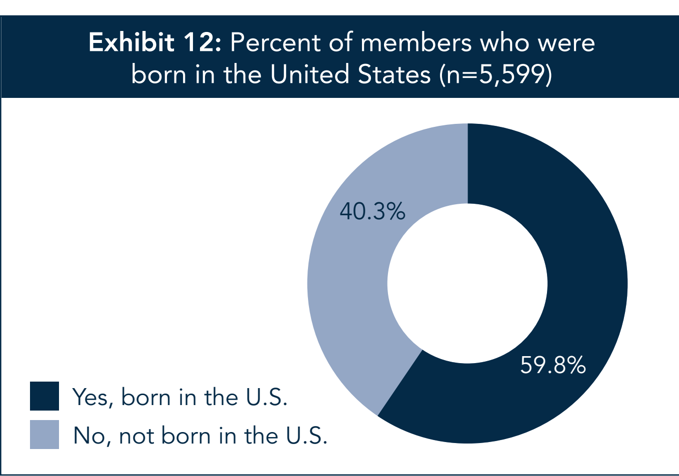



**Exhibit 12:** Percent of members who were born in the United States (n=5,599)




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)

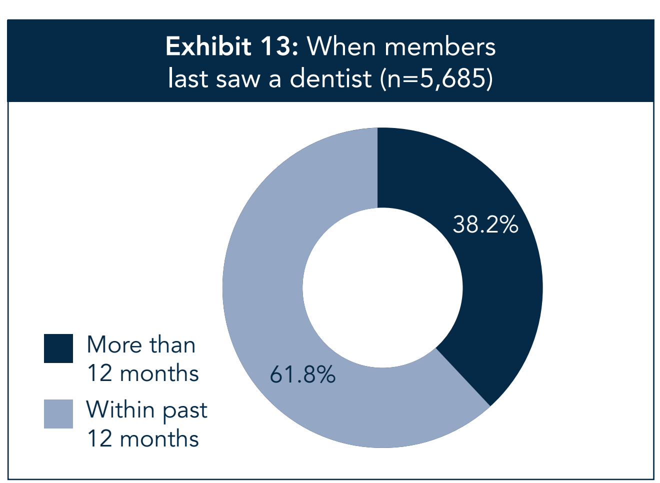
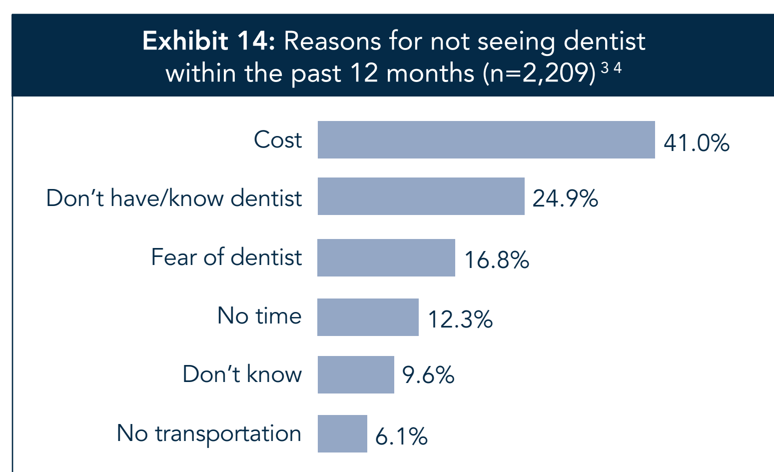



**Exhibit 14:** Reasons for not seeing dentist within the past 12 months (n=2,209) [3] [4]




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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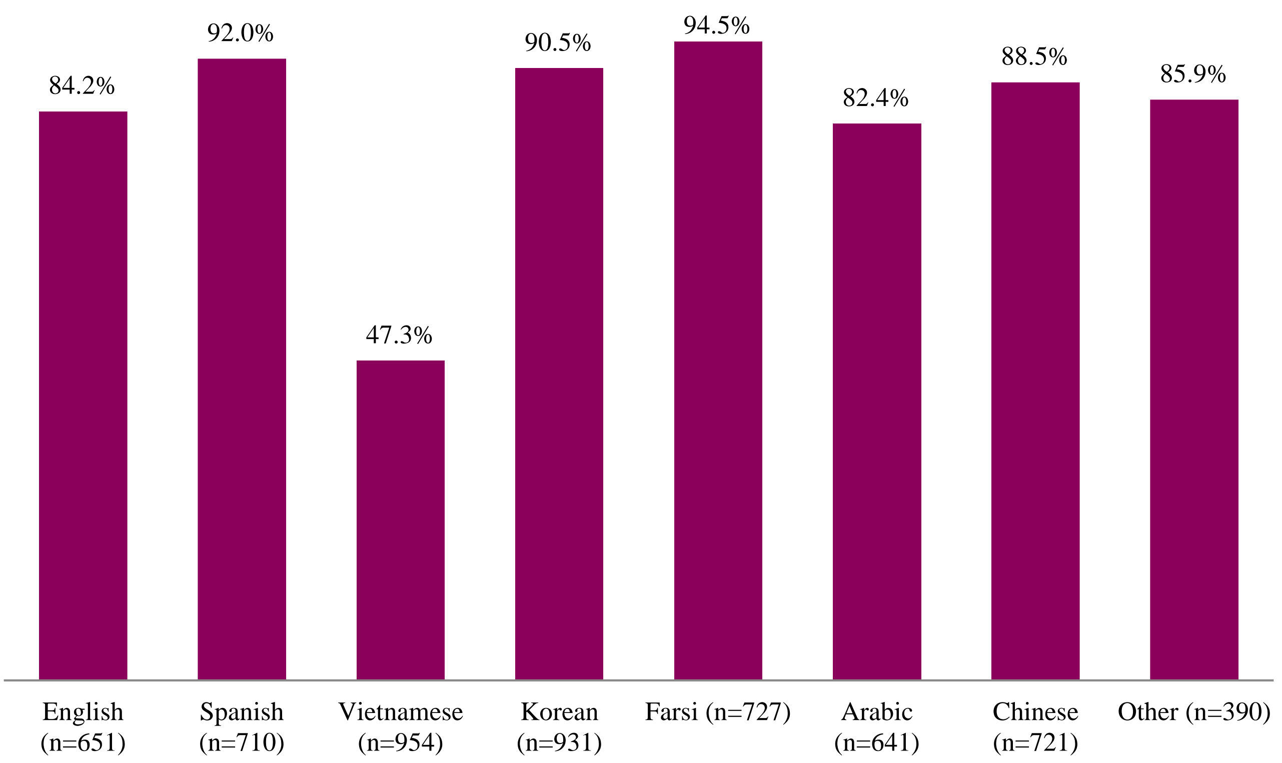
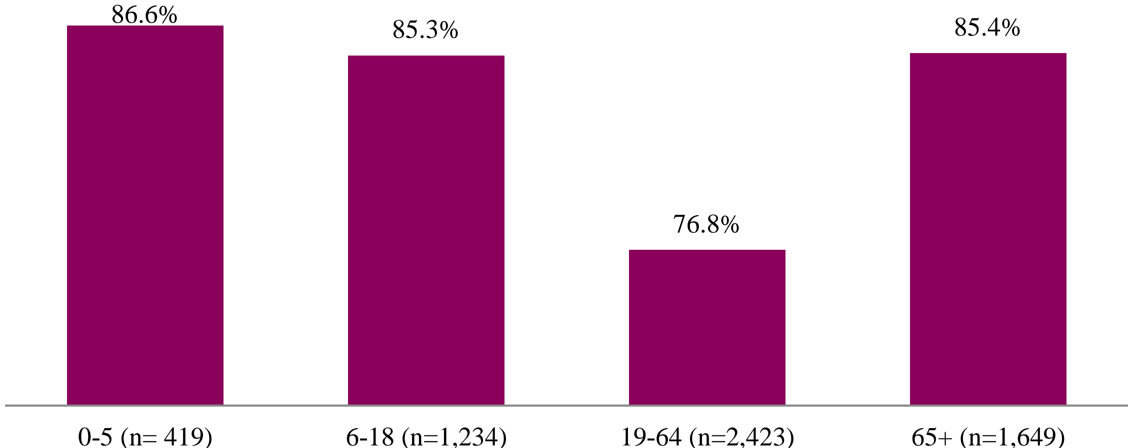
# Navigating the Healthcare System

**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.



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**Region:**

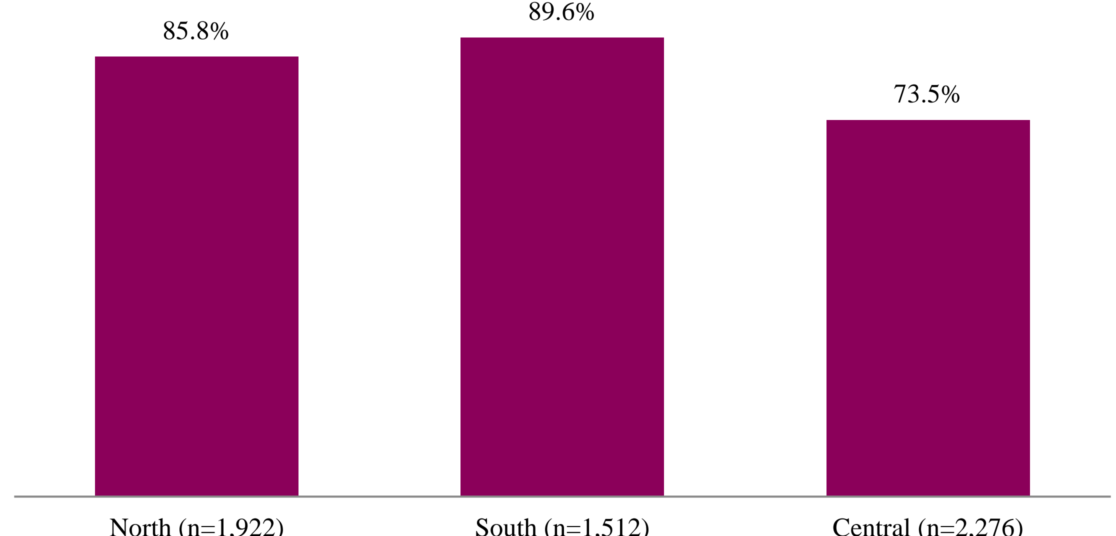

**Exhibit 2. Where respondents go to see their doctor**

**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%.**


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**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<br>% | Doctor helped schedule the appointment<br>% | Important for health<br>% | 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<br>% | Doctor helped schedule the appointment<br>% | Important for health<br>% | 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<br>% | Doctor helped schedule the appointment<br>% | Important for health<br>% | 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<br>% | No transportation<br>% | Appointments not at times that work with schedule<br>% | Takes too long to get an appointment<br>% | Didn't think needed to go<br>% | 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<br>% | No transportation<br>% | Appointments not at times that work with schedule<br>% | Takes too long to get an appointment<br>% | Didn't think needed to go<br>% | 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 |

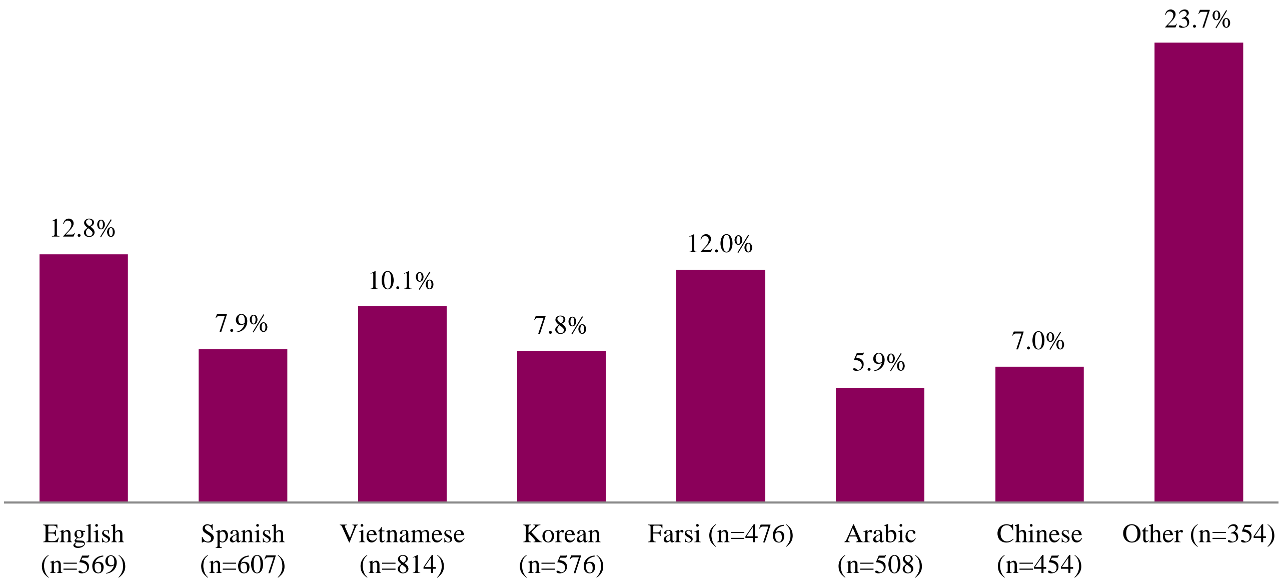
[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

**Region:**

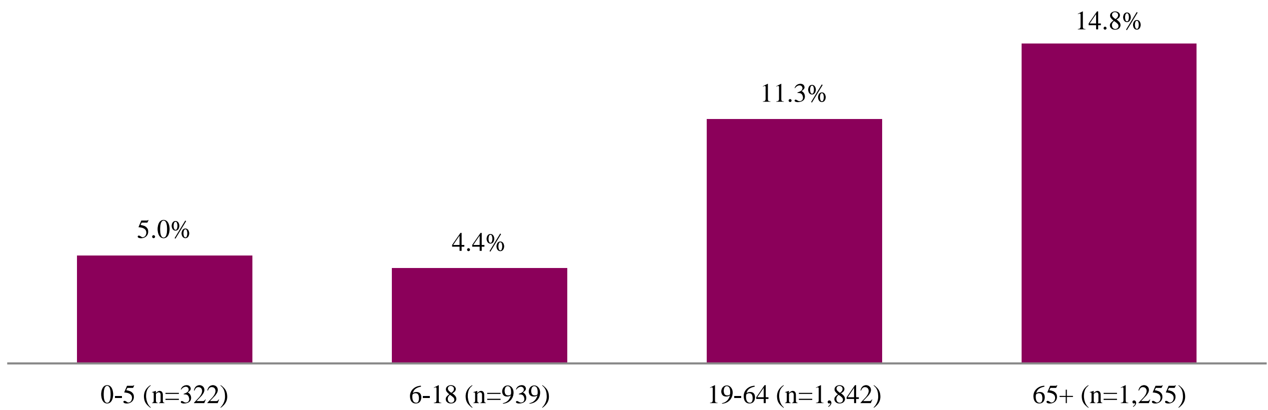
| Region | Too far away<br>% | No transportation<br>% | Appointments not at times that work with schedule<br>% | Takes too long to get an appointment<br>% | Didn't think needed to go<br>% | n |
|---|---|---|---|---|---|---|
| **North** | 14.0% | 11.3% | 24.8% | 35.9% | 31.1% | 1,567 |
| **South** | 13..6% | 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**

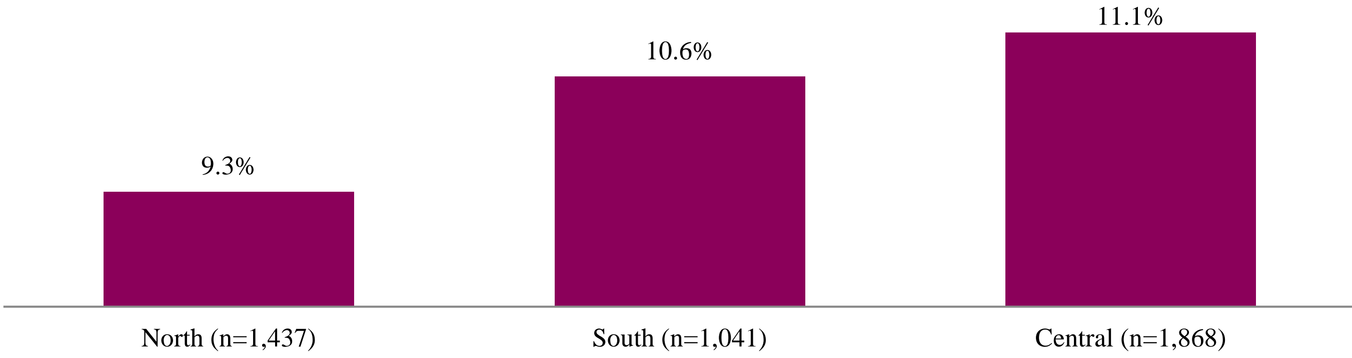
**CalOptima language:**




**Age Category:**




**Region:**



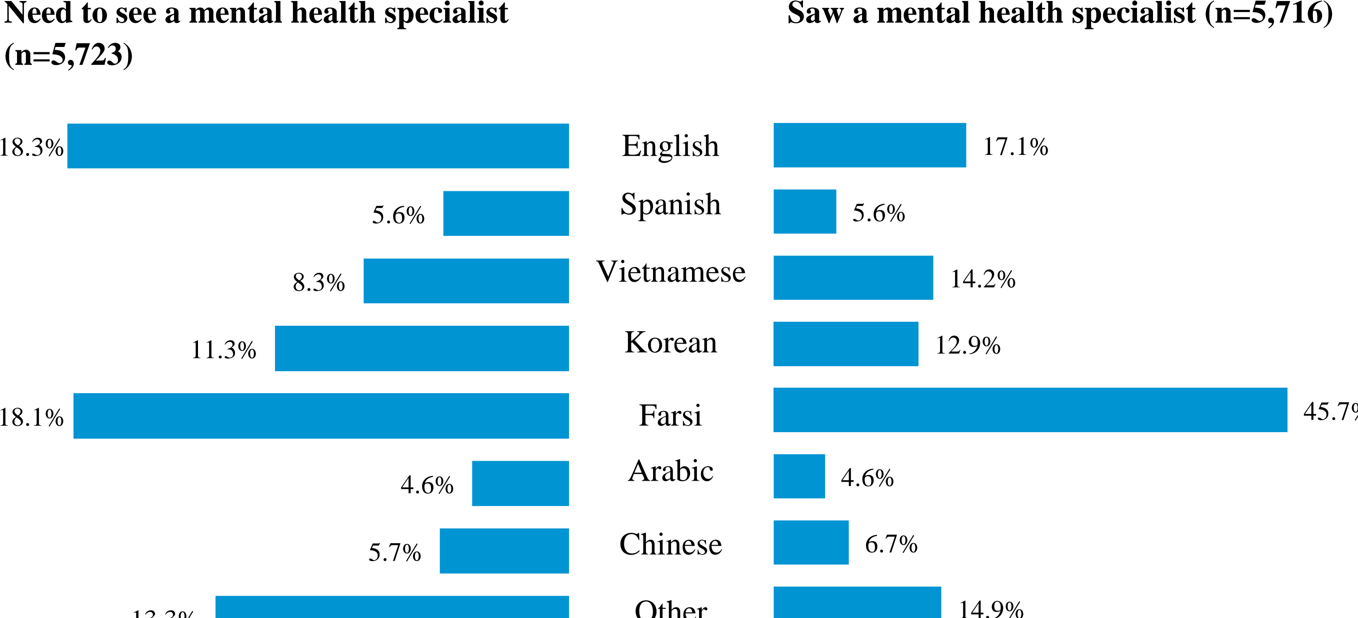
# Social and Emotional Well-Being

**Exhibit 9. Members who needed to see compared to those who saw a mental health specialist in the last 12 months[6]**

**CalOptima Language:**

**Need to see a mental health specialist (n=5,723)**

**Saw a mental health specialist (n=5,716)**

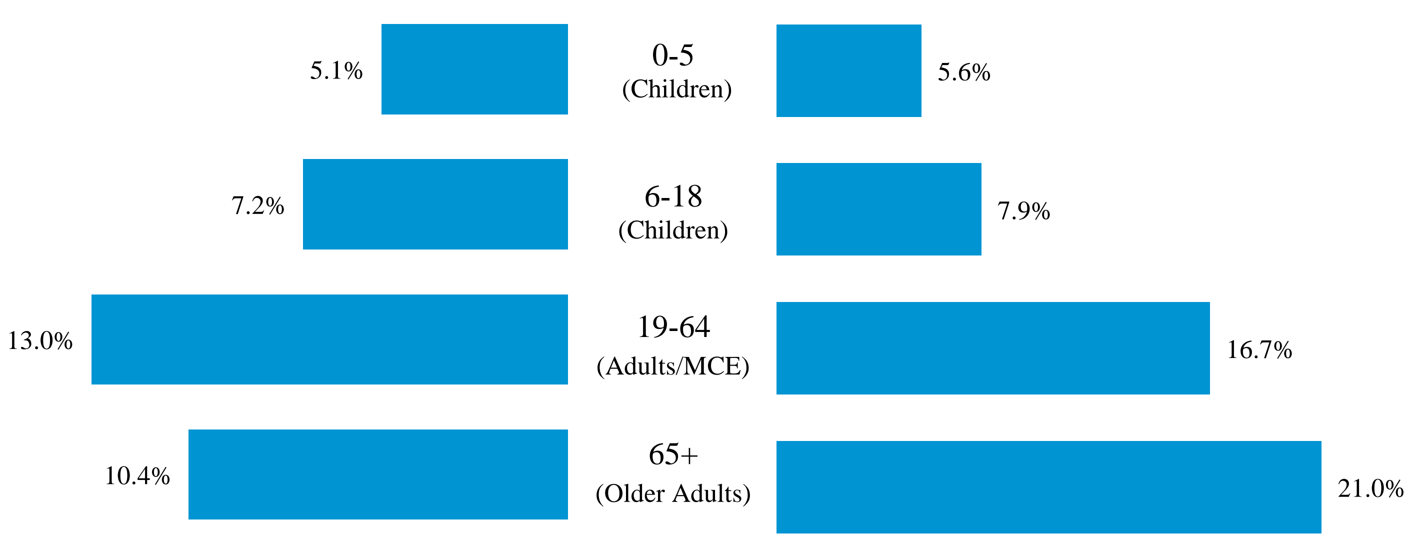



[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

**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)**

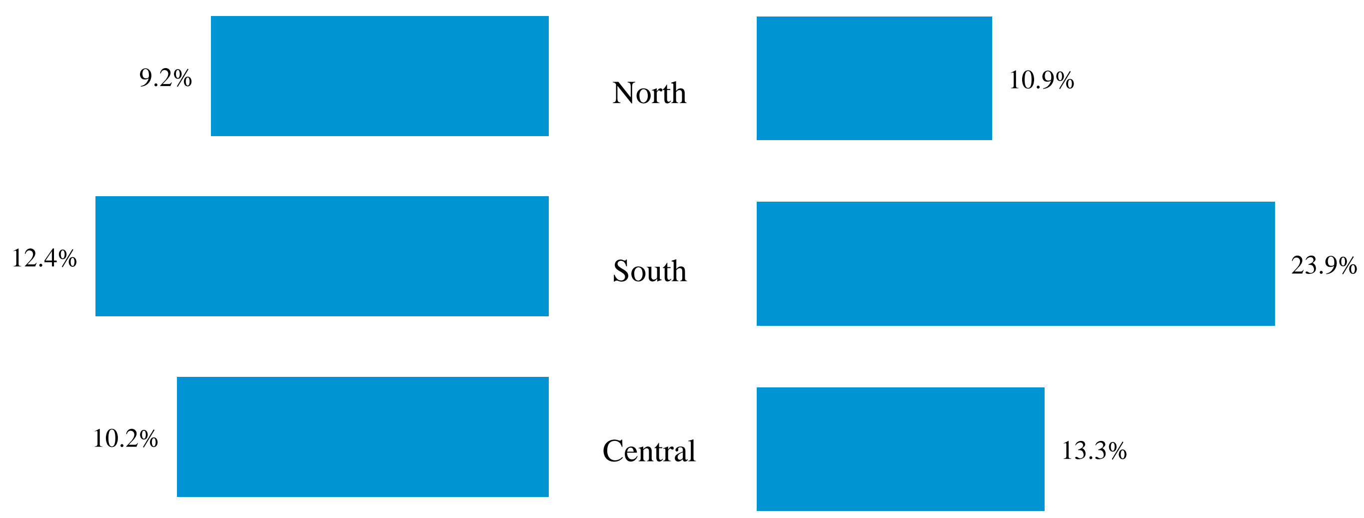
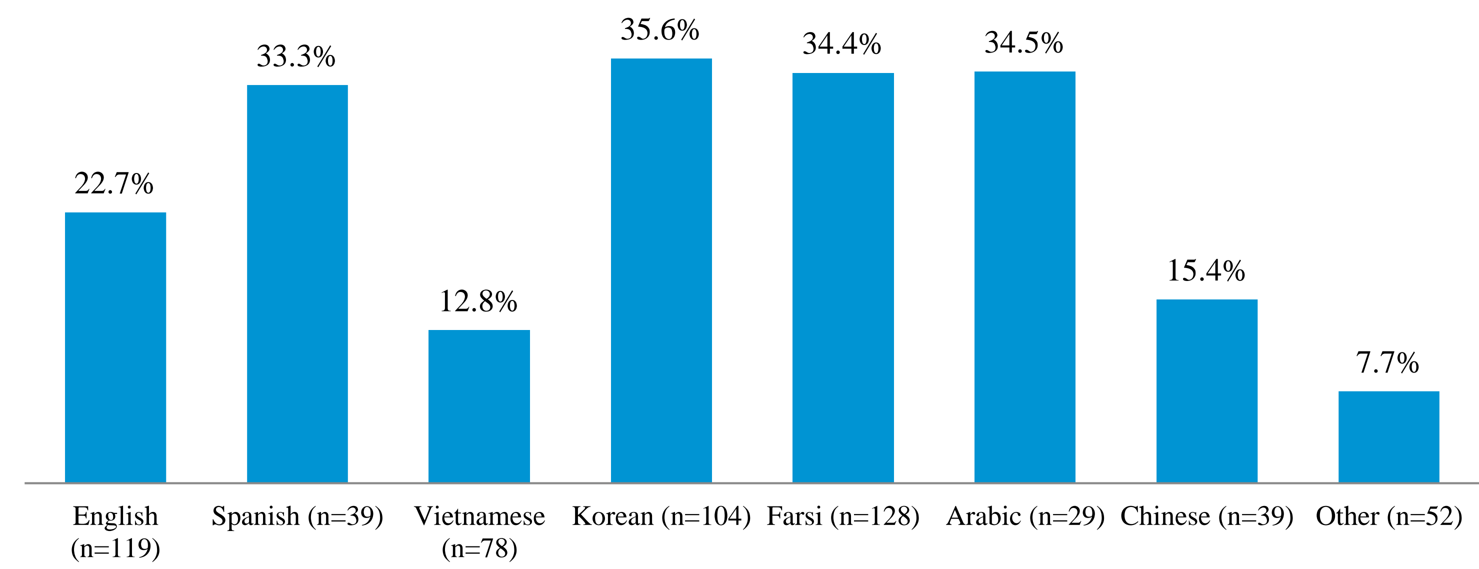
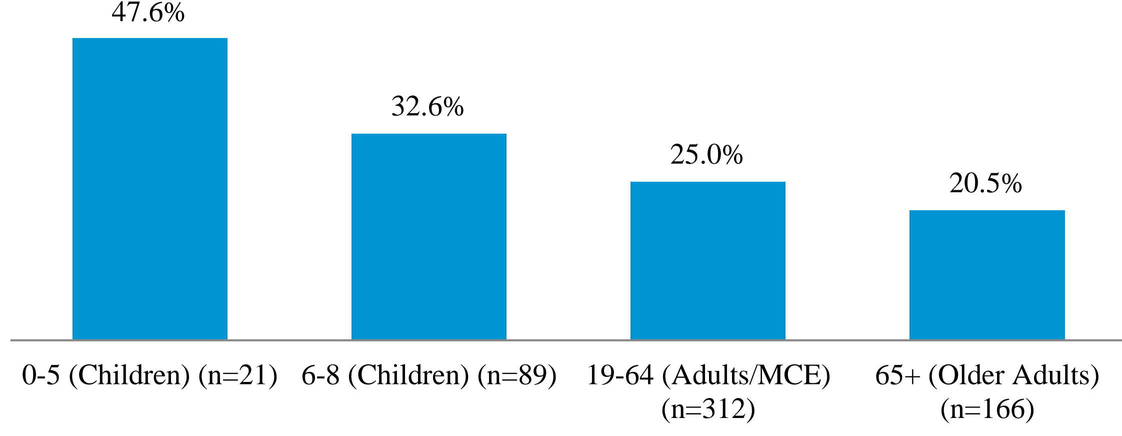


**Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist**

**CalOptima Language:**




**Age Category:**




**Region:**

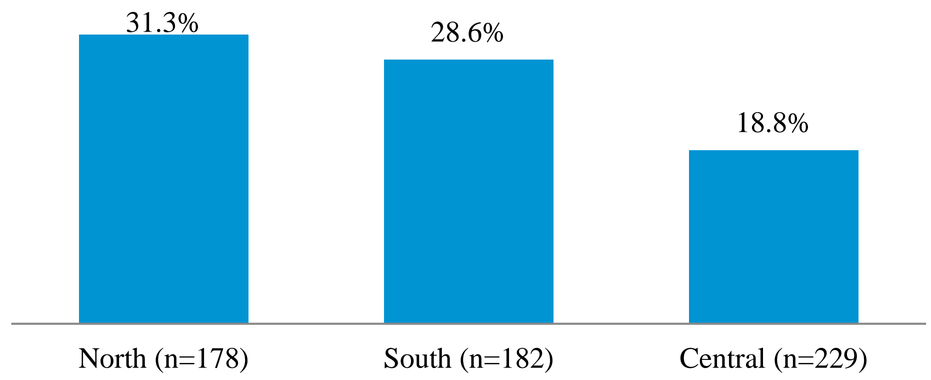
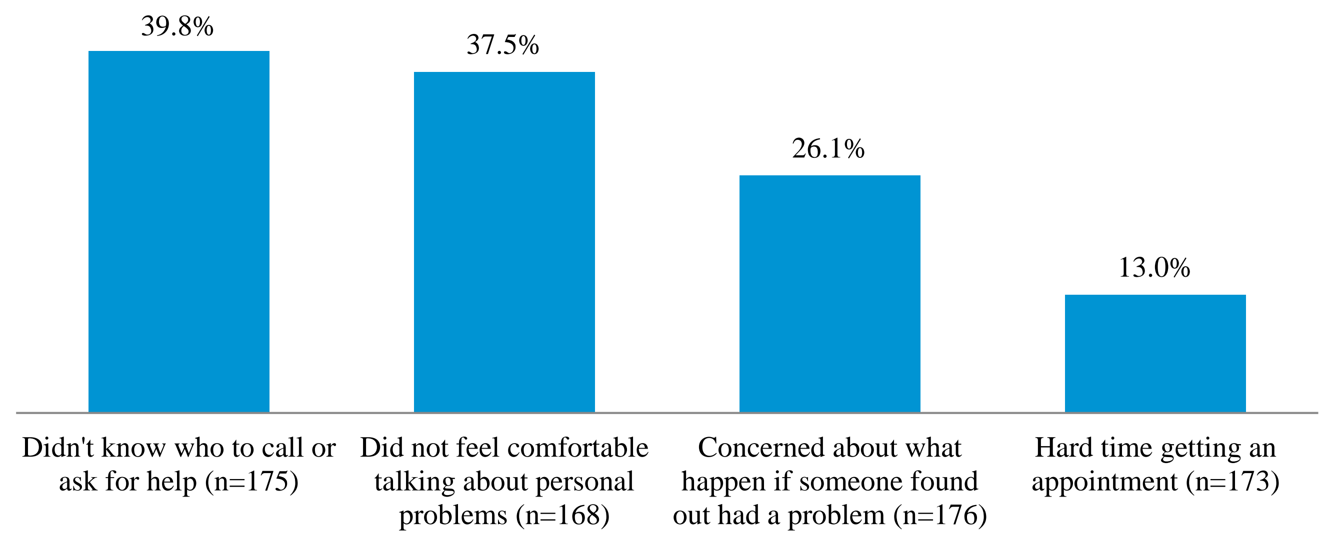


**Exhibit 11. Reasons why members didn't see mental health specialist**[7]




[7] Among those who indicated that they needed to see a mental health specialist but did not see one.



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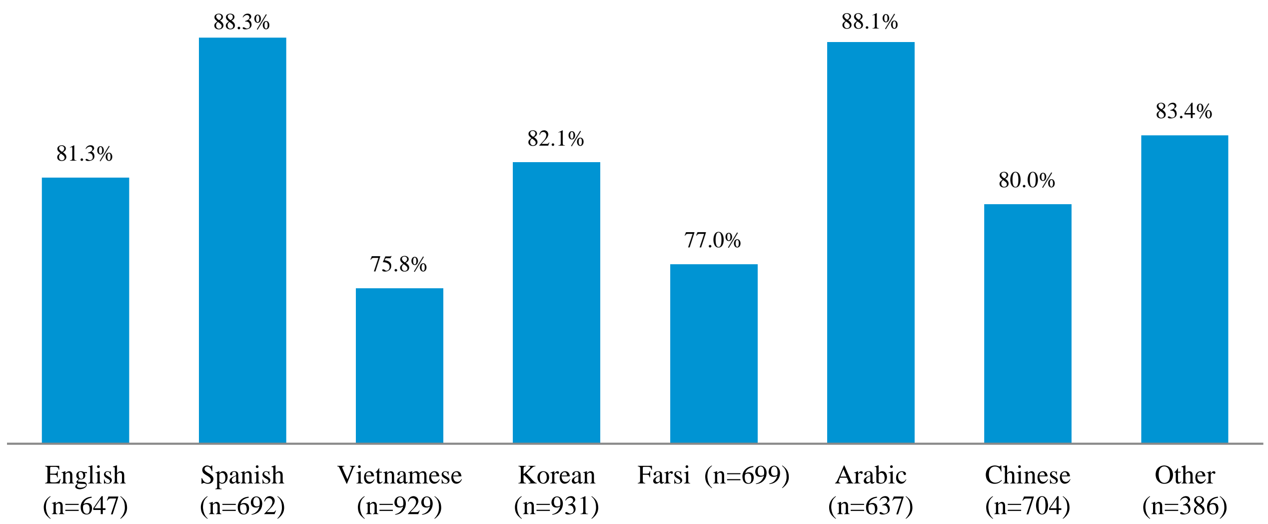
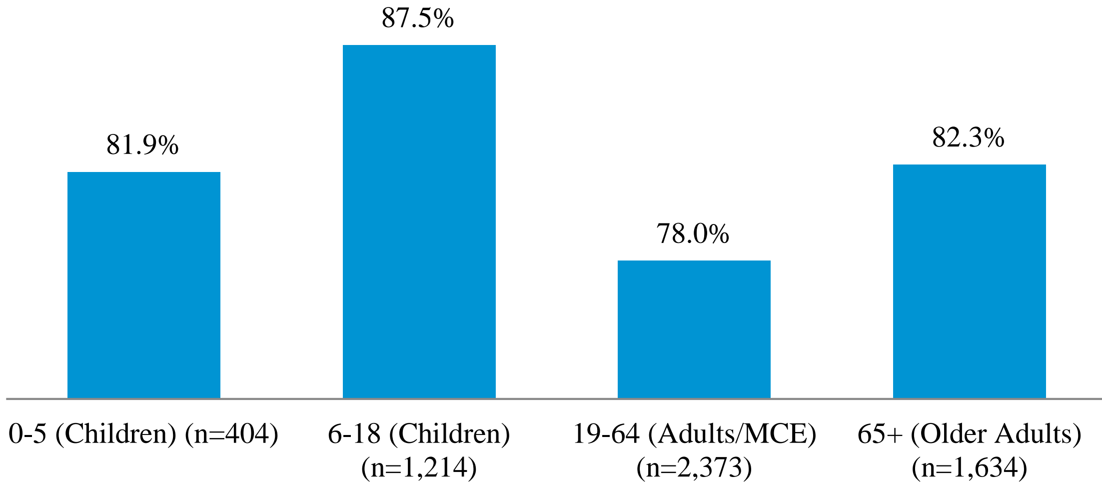
**Exhibit 12. Percent of members who can share their worries with family members**

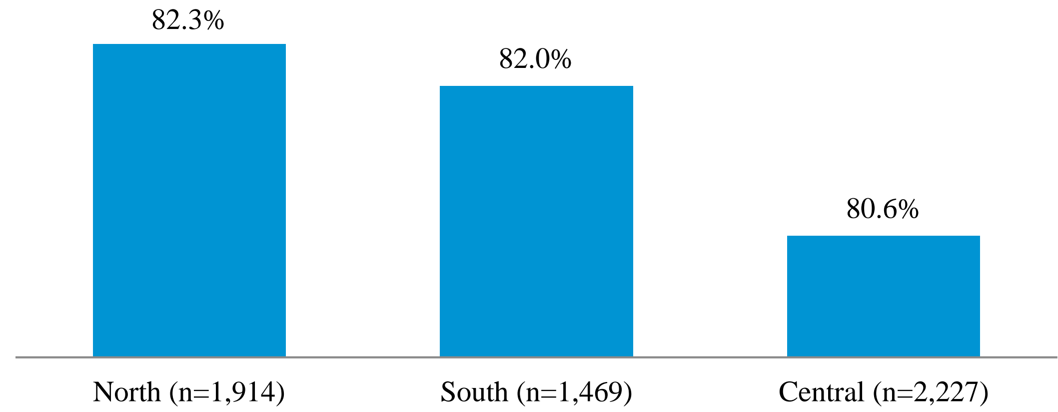
**CalOptima language:**




**Age Category:**




**Region:**

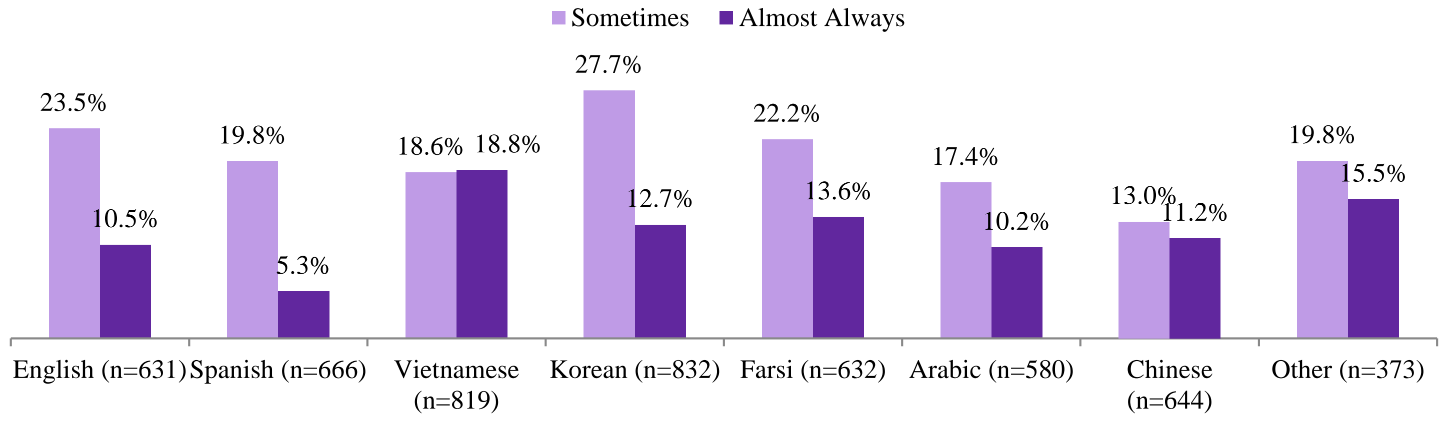


# Social Determinants of Health

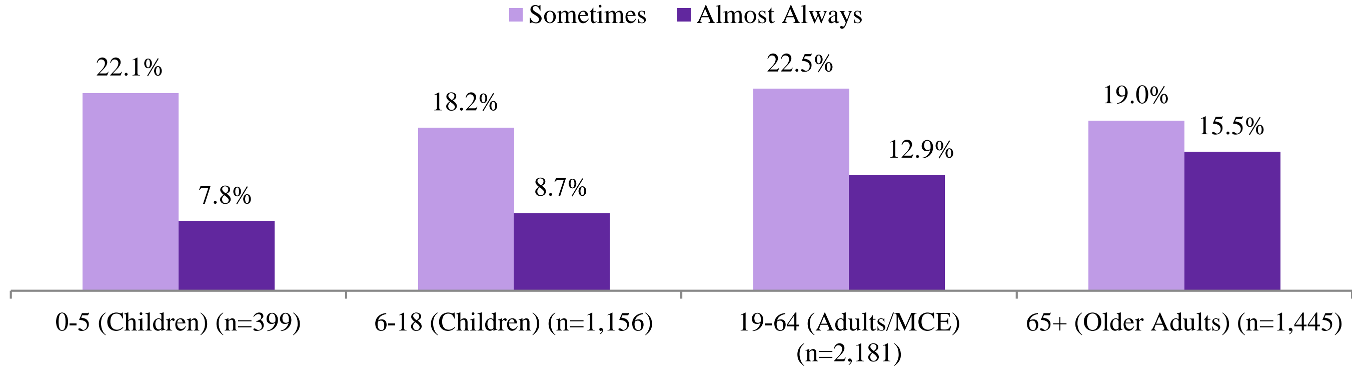
**Exhibit 13. Needed help with the following in the past 6 months:**

**Food for anyone in your household:**

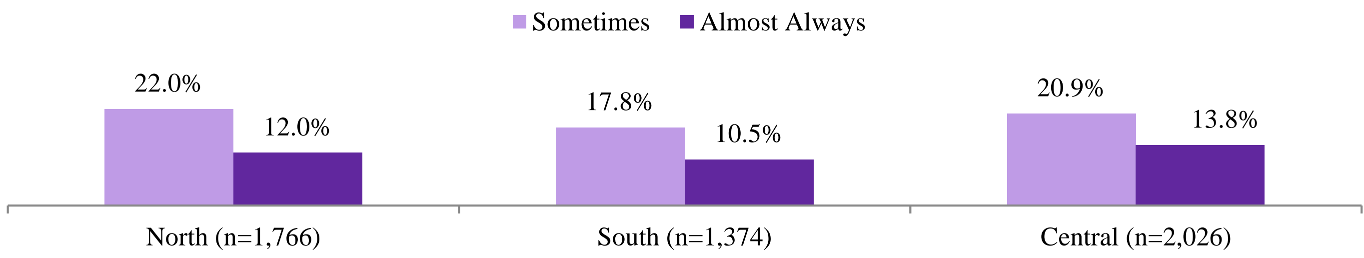
**CalOptima language:**




**Age Category:**



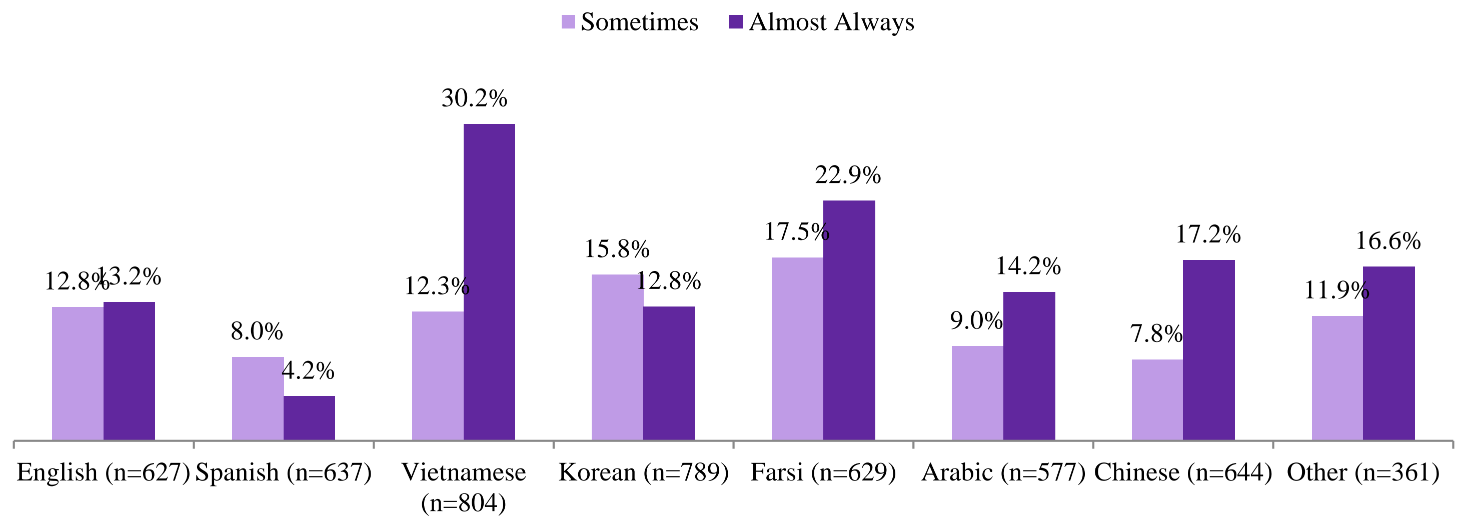

**Region:**



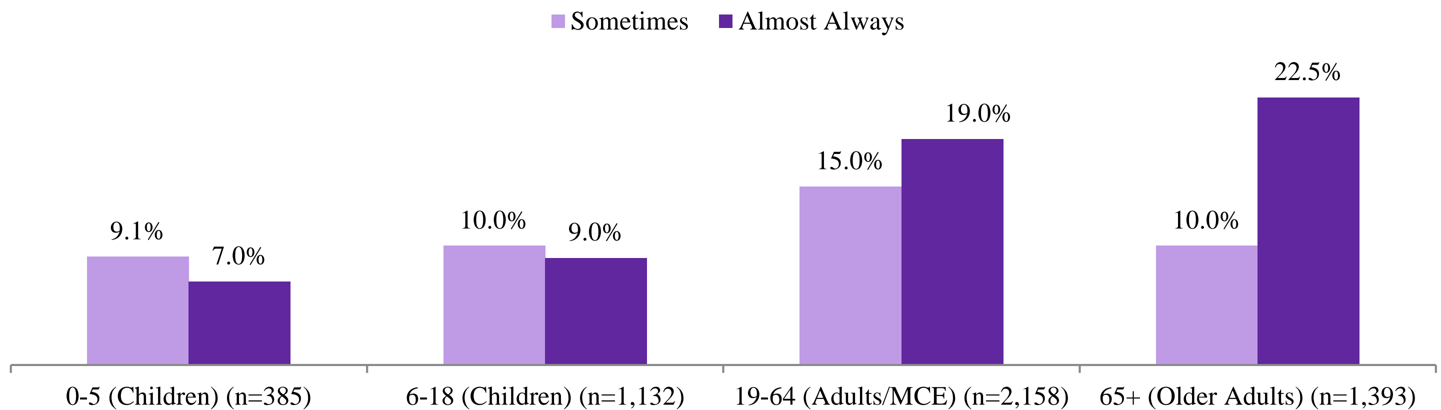
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Housing:**

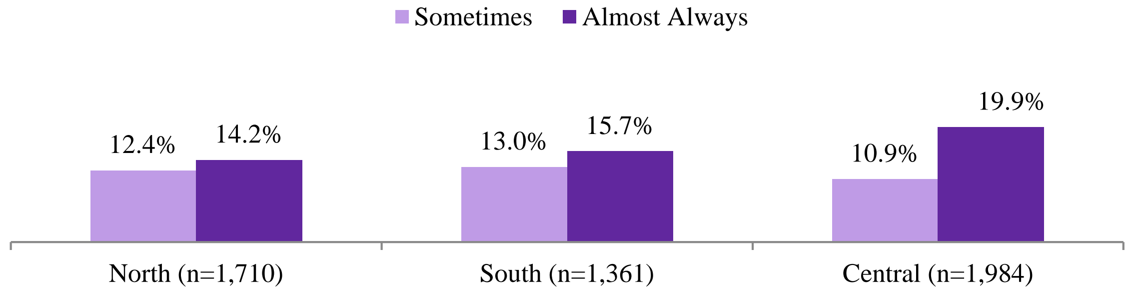
**CalOptima language:**




**Age Category:**

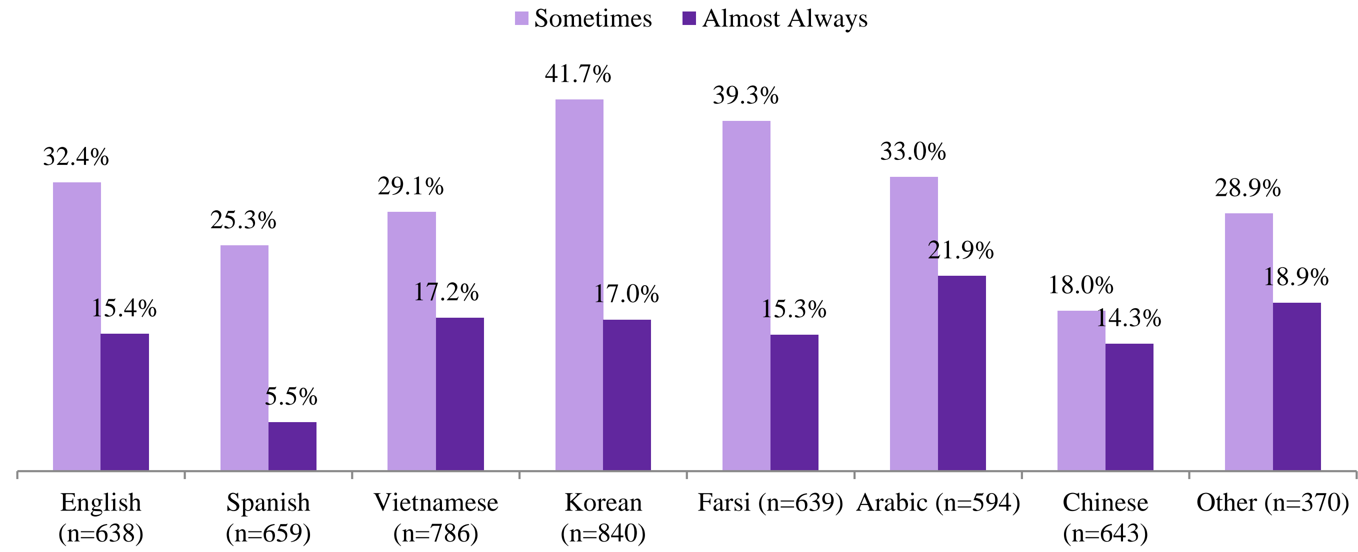



**Region:**

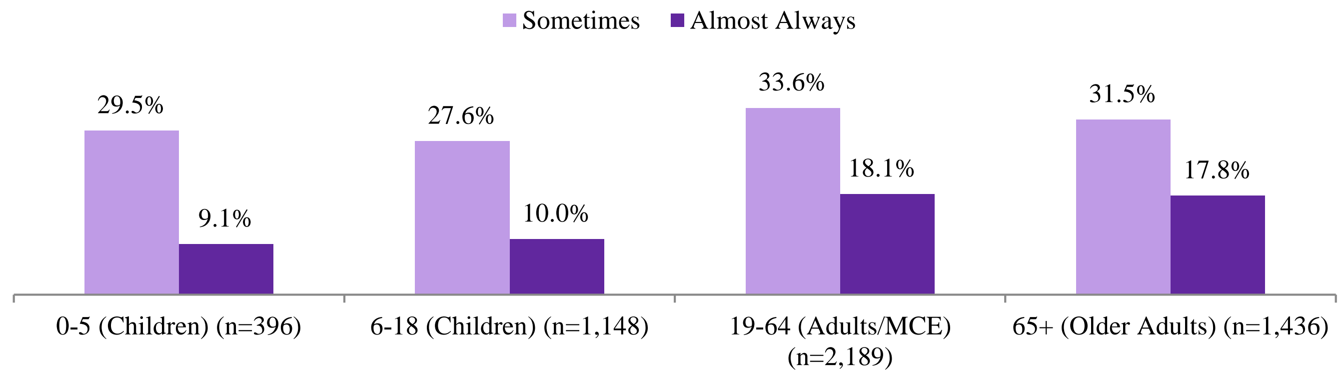


**Money to buy things need:**

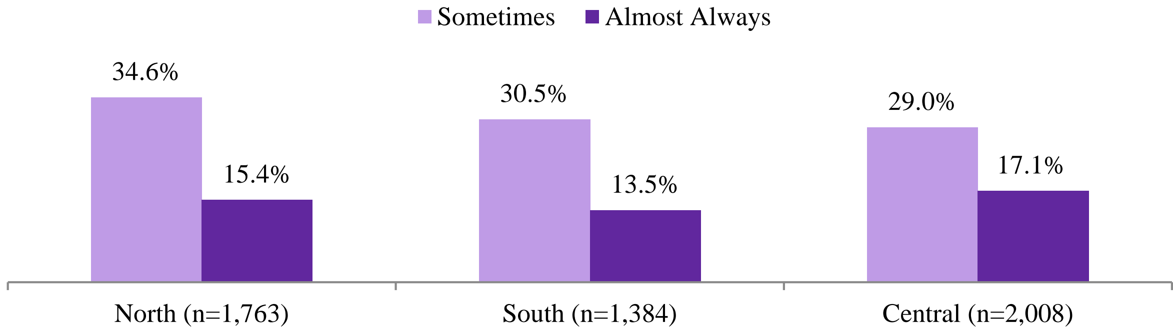
**CalOptima language:**




**Age Category:**

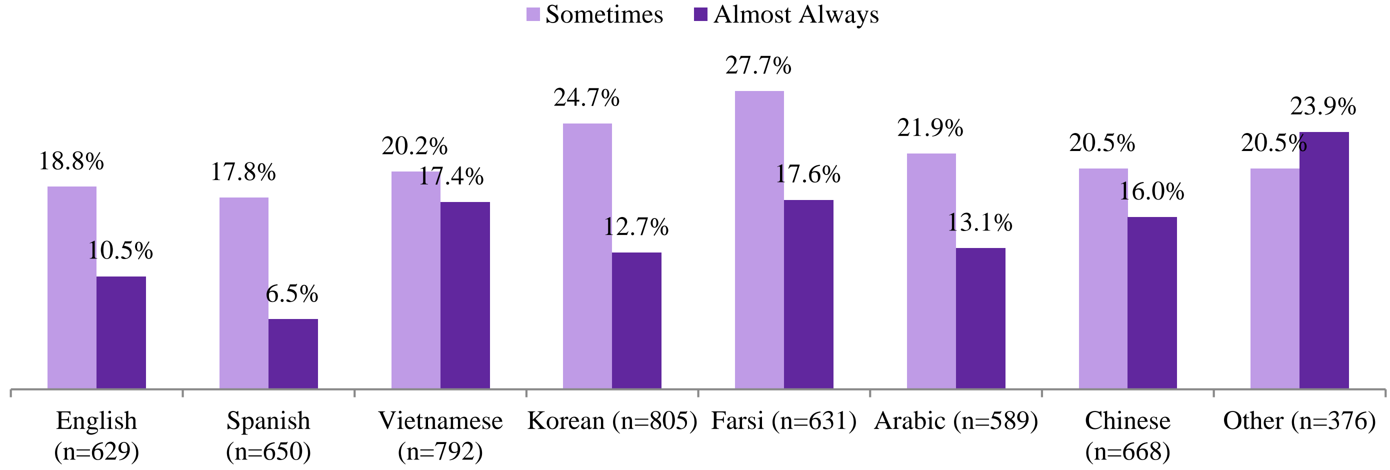



**Region:**

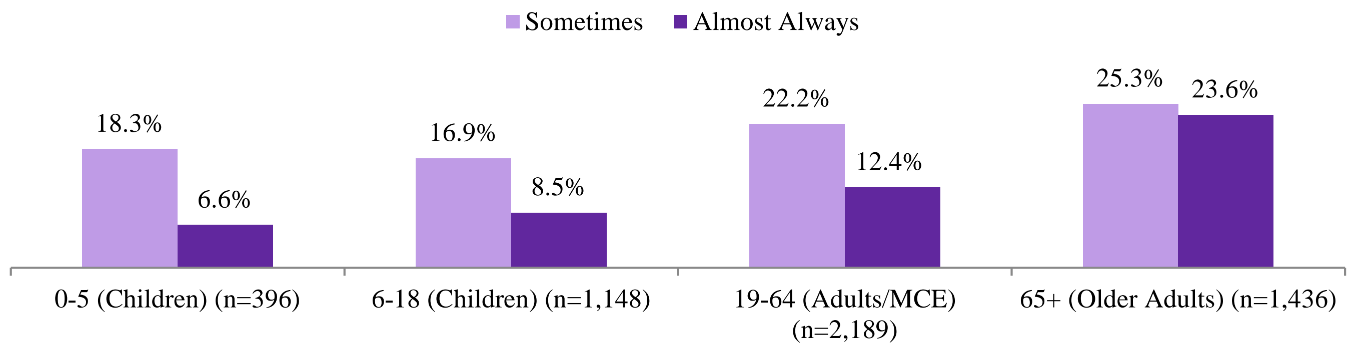


**Transportation:**

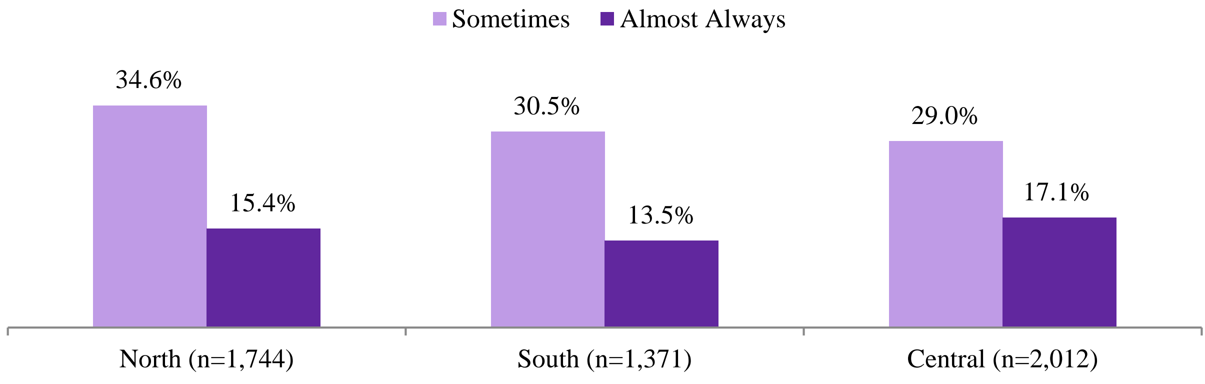
**CalOptima language:**




**Age Category:**

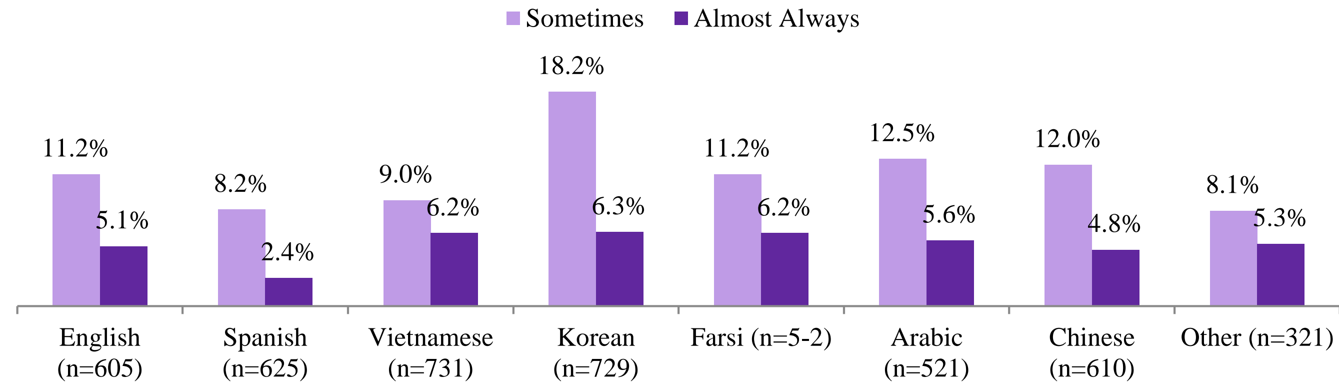



**Region:**

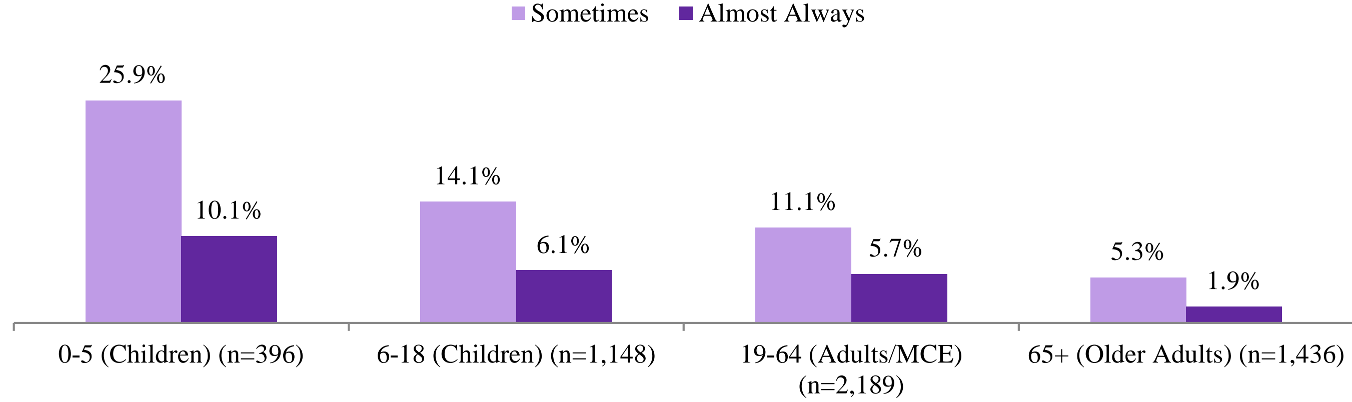


**Child care:**

**CalOptima language:**




**Age Category:**




**Region:**

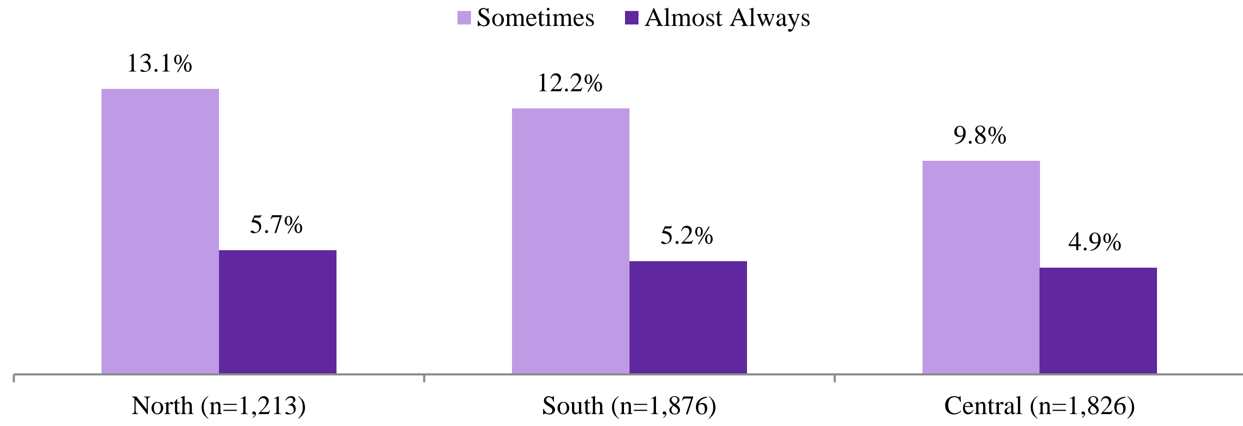
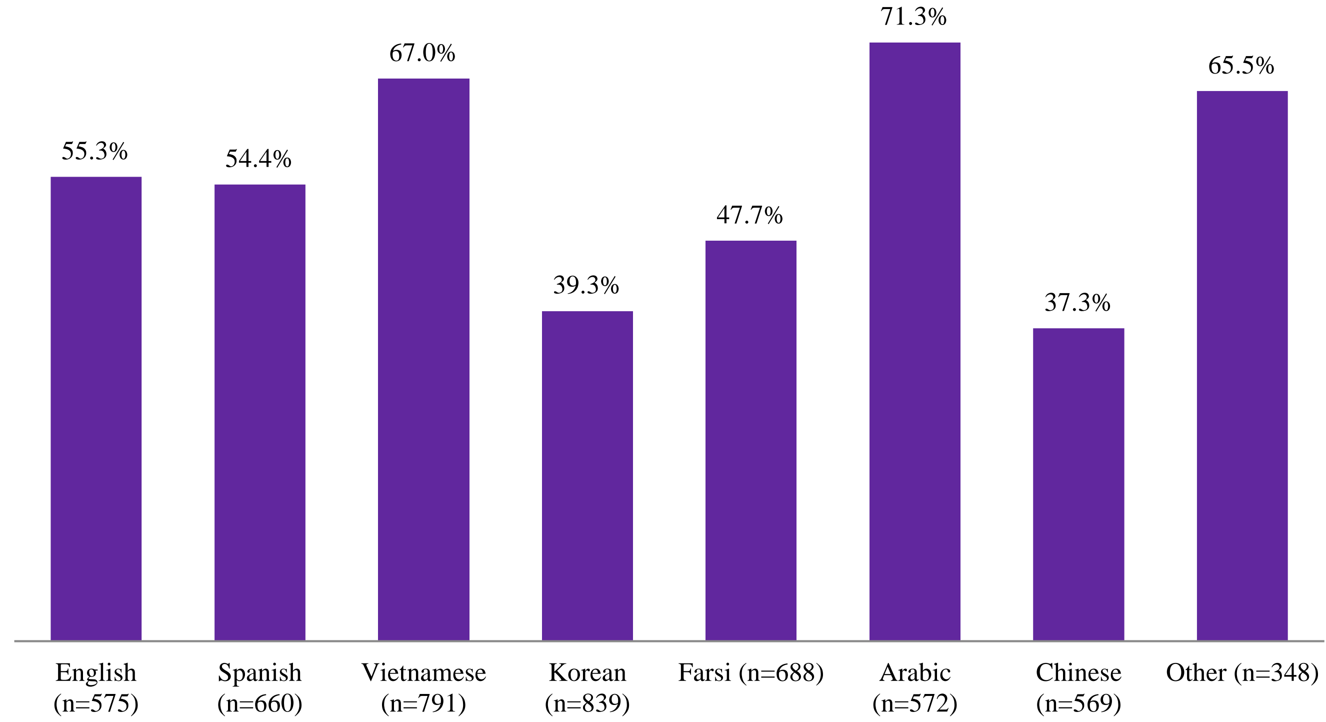


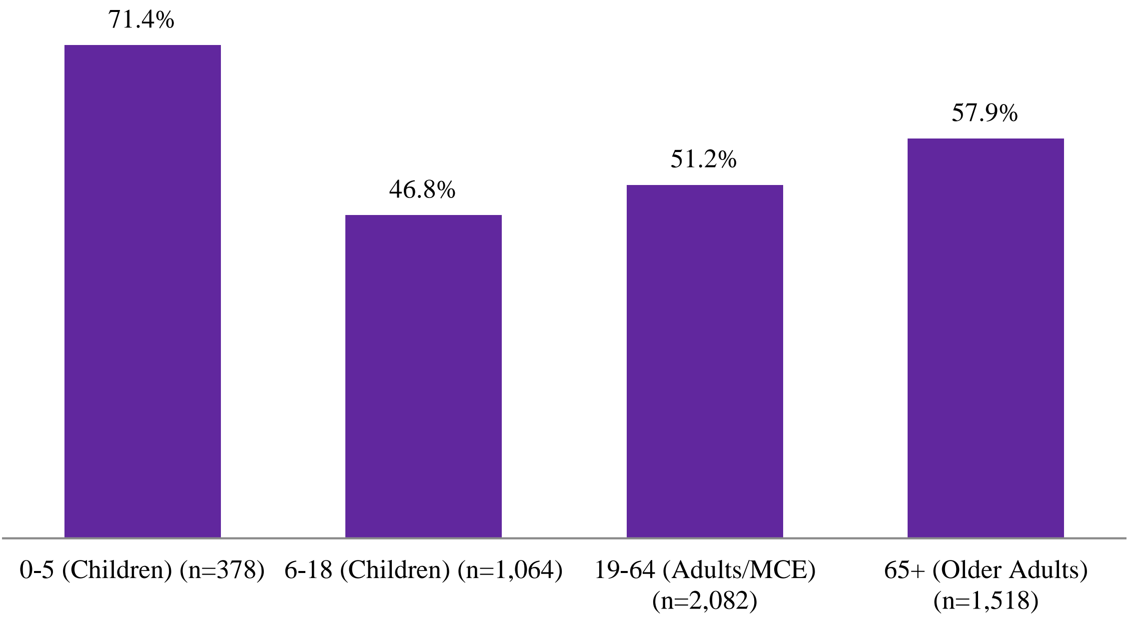
**Exhibit 14. Members who received public benefits**

**Percent of members who receive public benefits:**

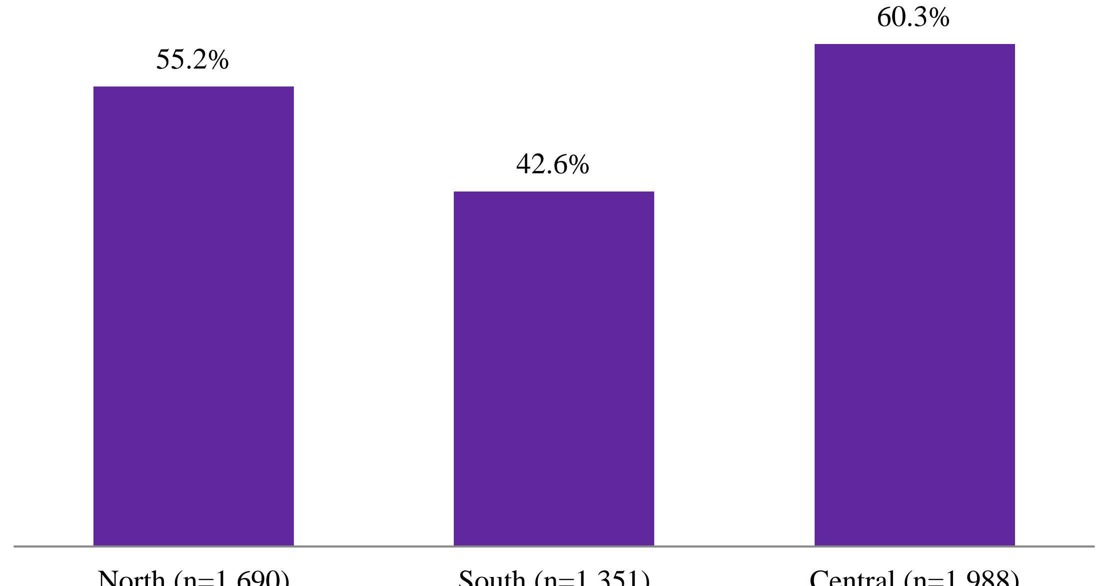
**CalOptima language:**




**Age Category:**



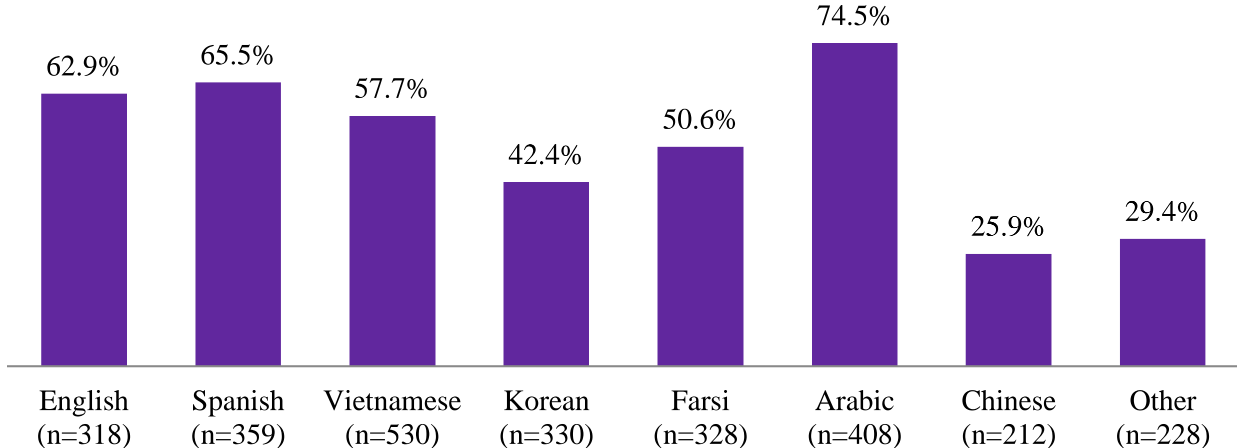
**Region:**



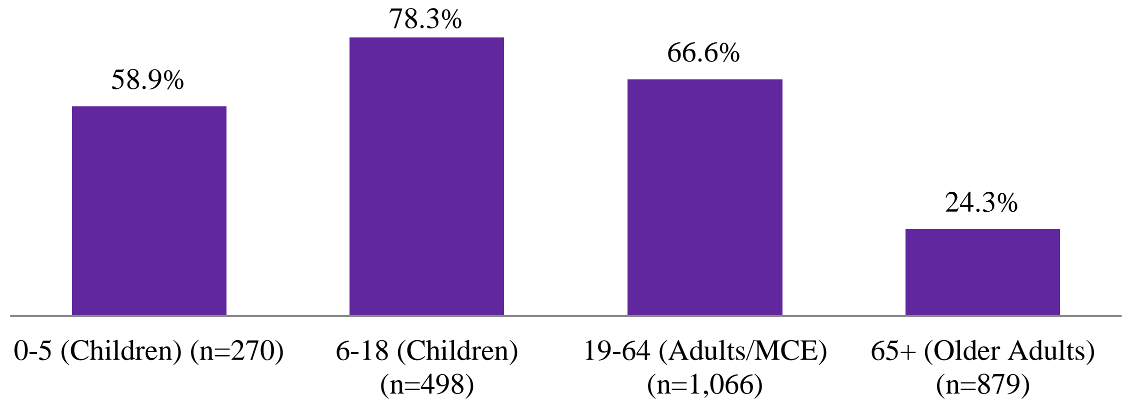
**Type of public benefits that members receive[8]:**

**Receive CalFresh as a public benefit:**

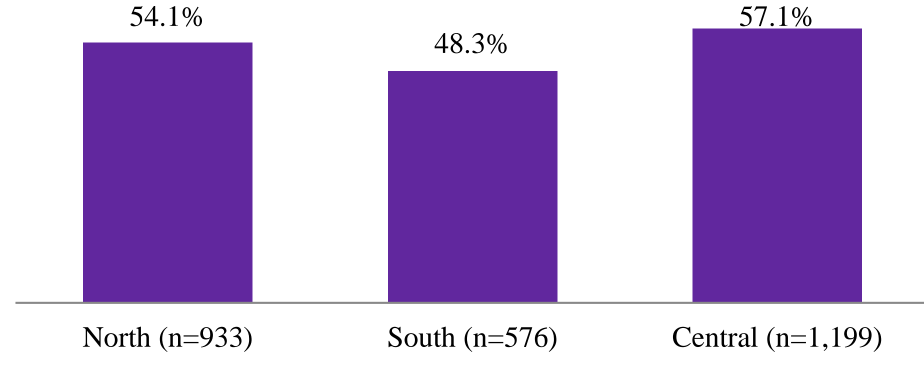
**CalOptima language:**




**Age Category:**



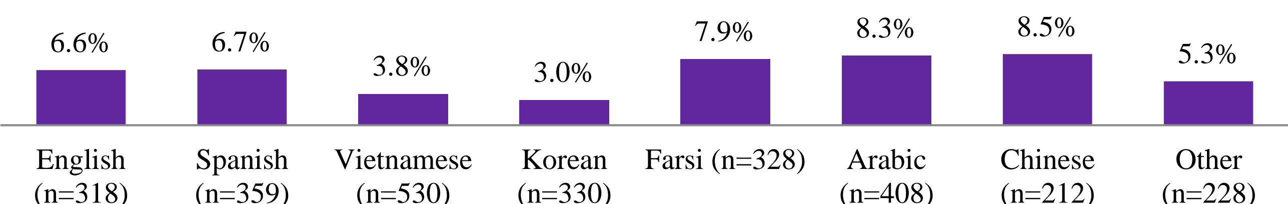

**Region:**



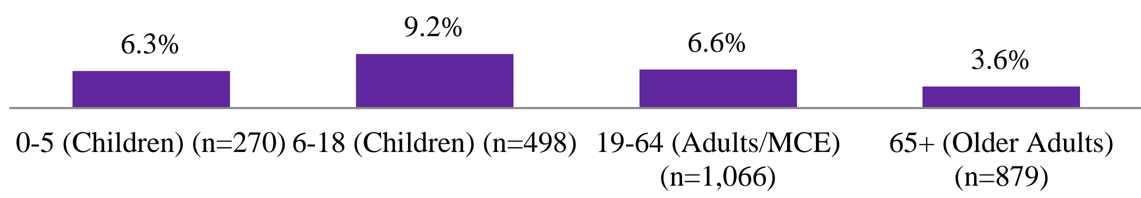

[8] Only reporting those who reported that they received at least one public benefit.

**Receive TANF or CalWorks as a public benefit:**

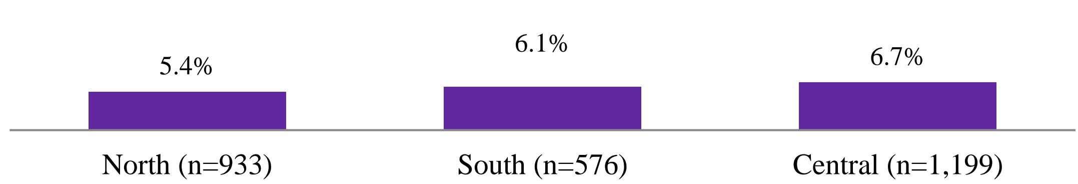
**CalOptima language:**




**Age Category:**

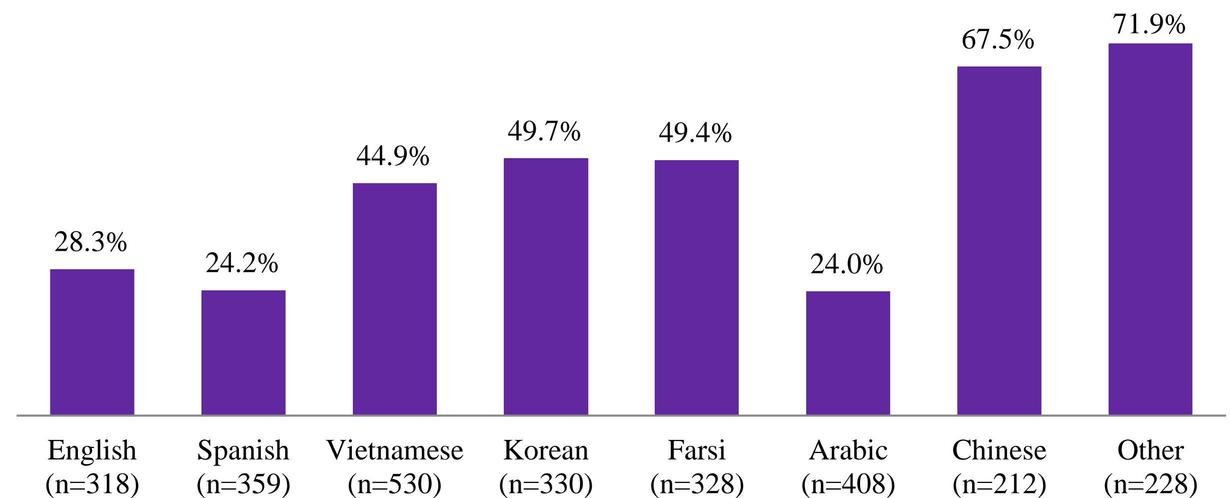



**Region:**

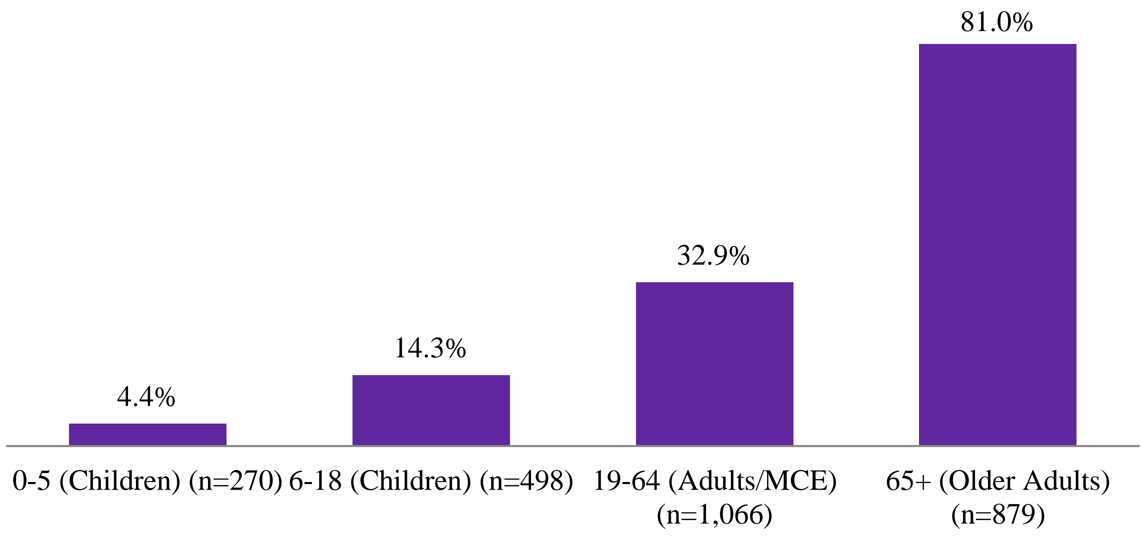


**Receive SSI or SSDI as a public benefit:**

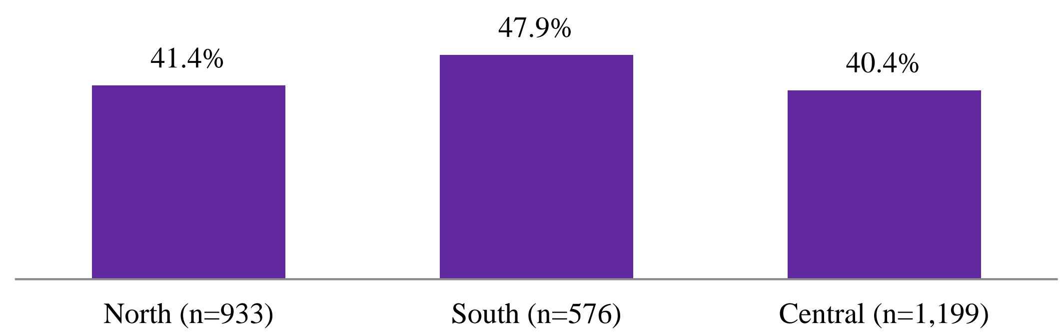
**CalOptima language:**




**Age Category:**

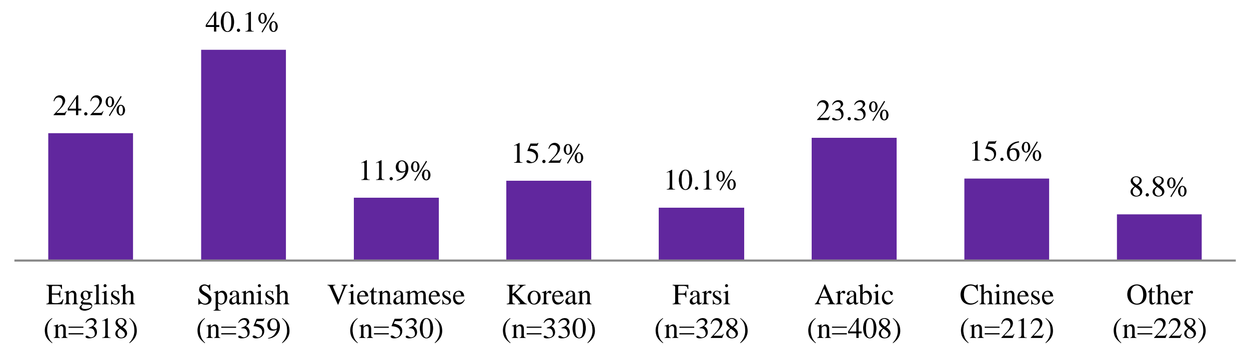



**Region:**

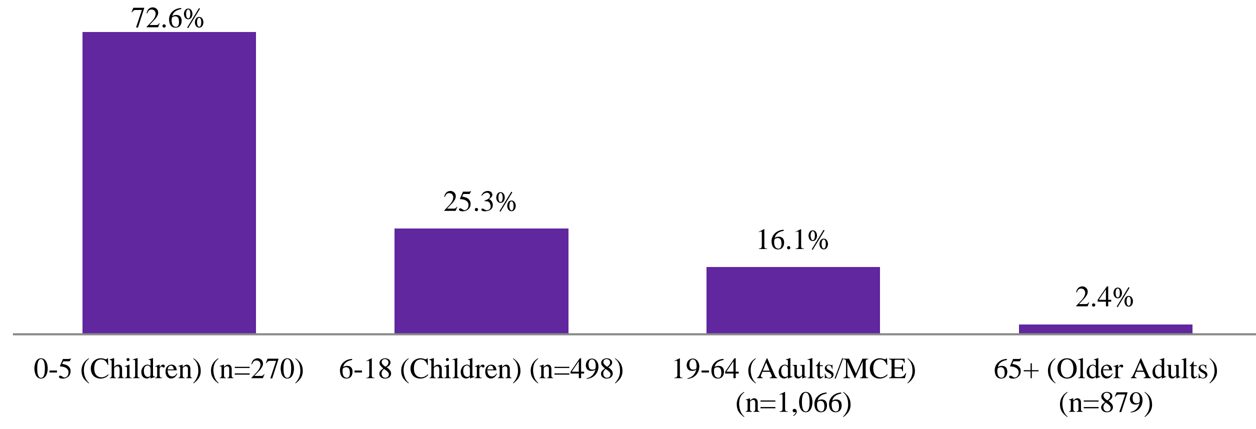


**Receive WIC as a public benefit:**

**CalOptima language:**




**Age Category:**




**Region:**

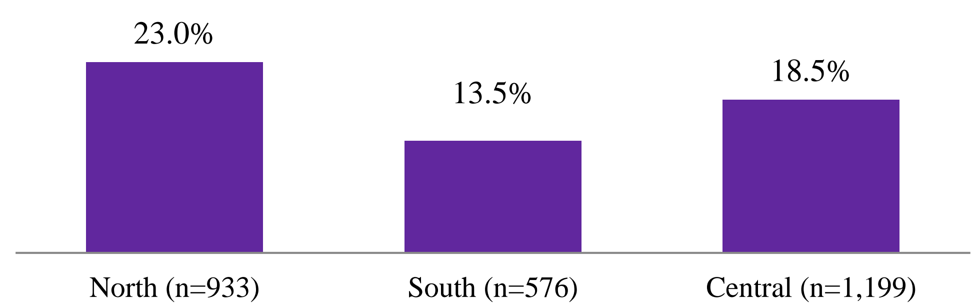


**Exhibit 15. Personal activities participation:**

**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 |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| Volunteer or charity | Once a week<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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 |


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| Get enough sleep | Once a week<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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 |


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| 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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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 |


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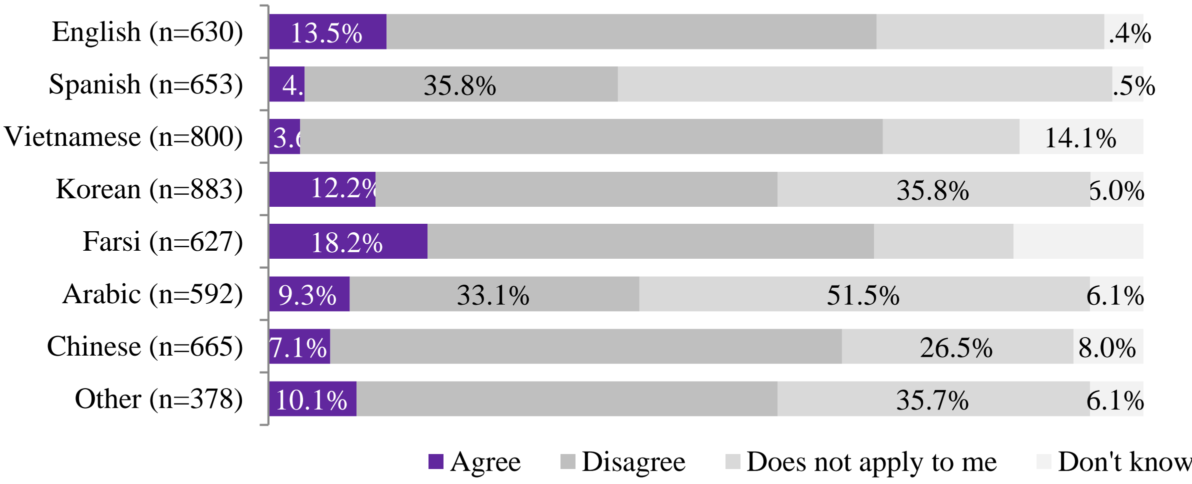
| Get enough sleep | Once a week % | Once a month % | Once in the last 6 months % | Never % | n |
|---|---|---|---|---|---|
| **North** | 86.8% | 4.7% | 0.8% | 7.7% | 1,668 |
| **South** | 86.0% | 5.3% | 1.8% | 6.9% | 1,230 |
| **Central** | 79.9% | 6.6% | 1.7% | 11.8% | 1,848 |
| **Have enough time 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 |

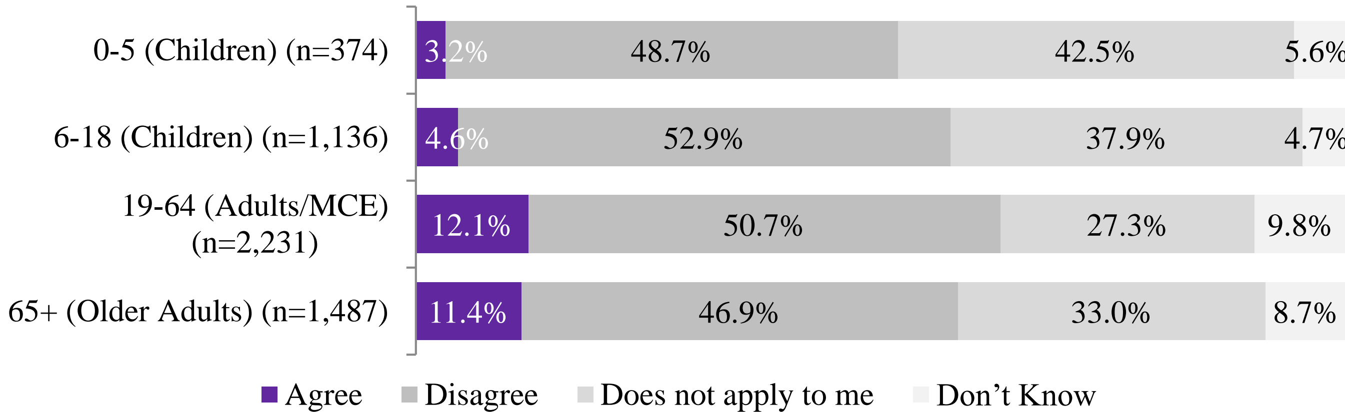
**Exhibit 16. Feelings towards community and home enviroment:**

**Feeling lonely and isolated:**

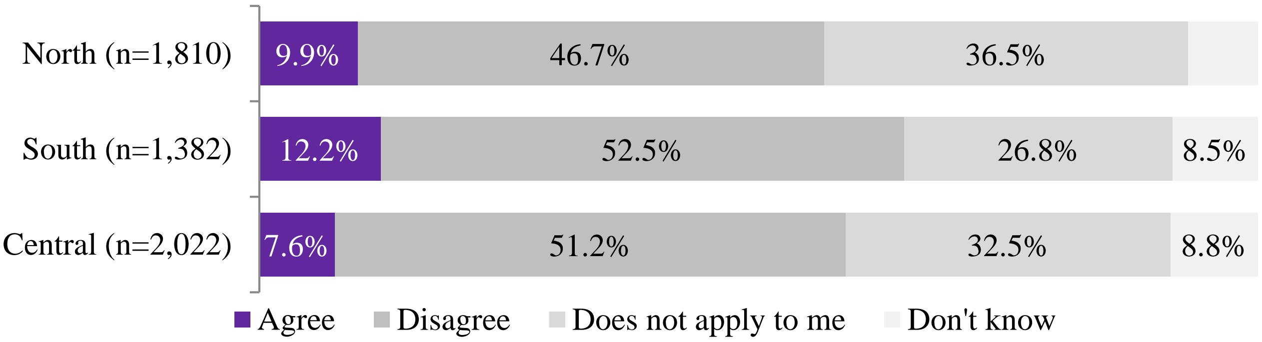
**CalOptima language:**




**Age Category:**




**Region:**





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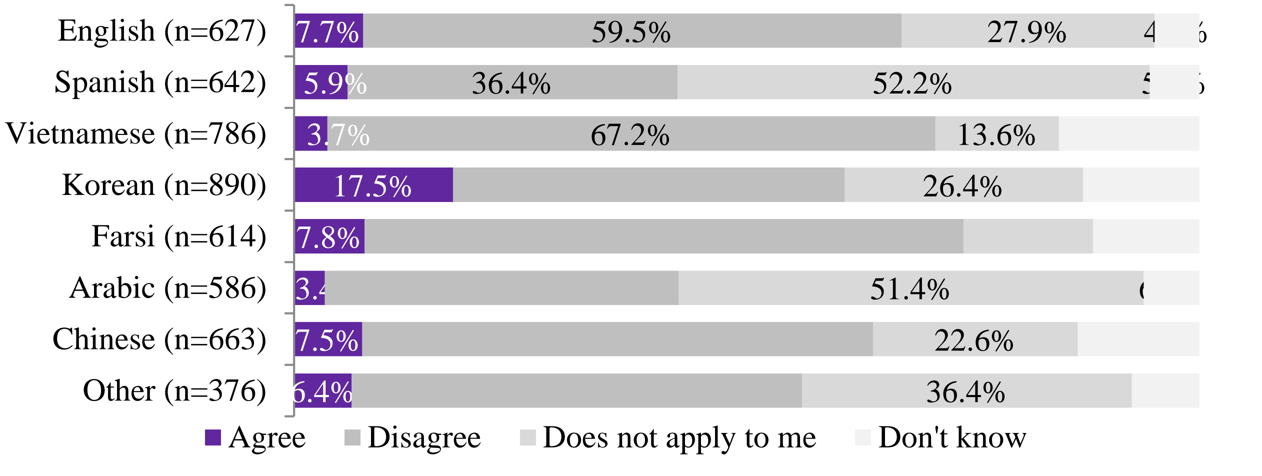
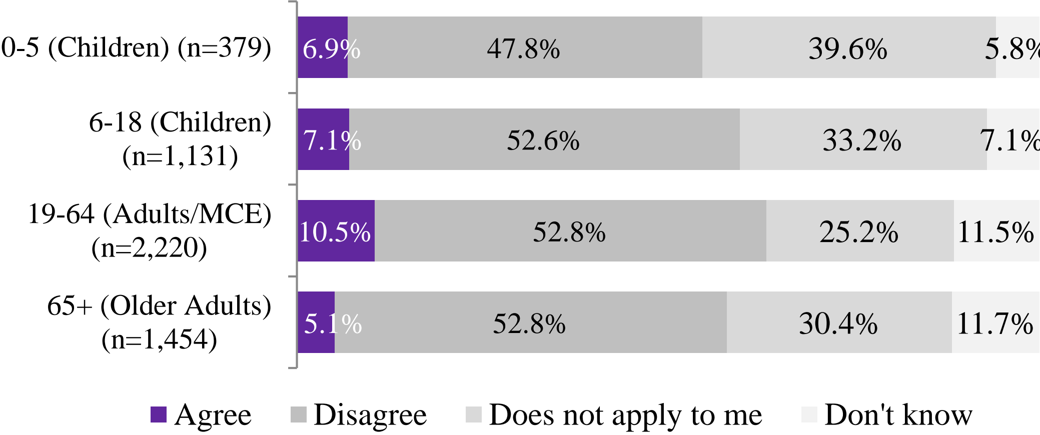
**Feel not treated equally because of ethnic and culutral backgrounds:**

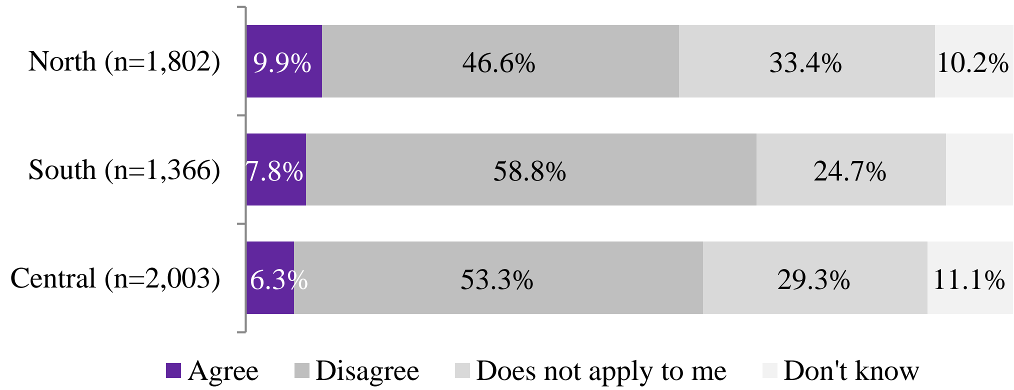
**CalOptima language:**




**Age Category:**

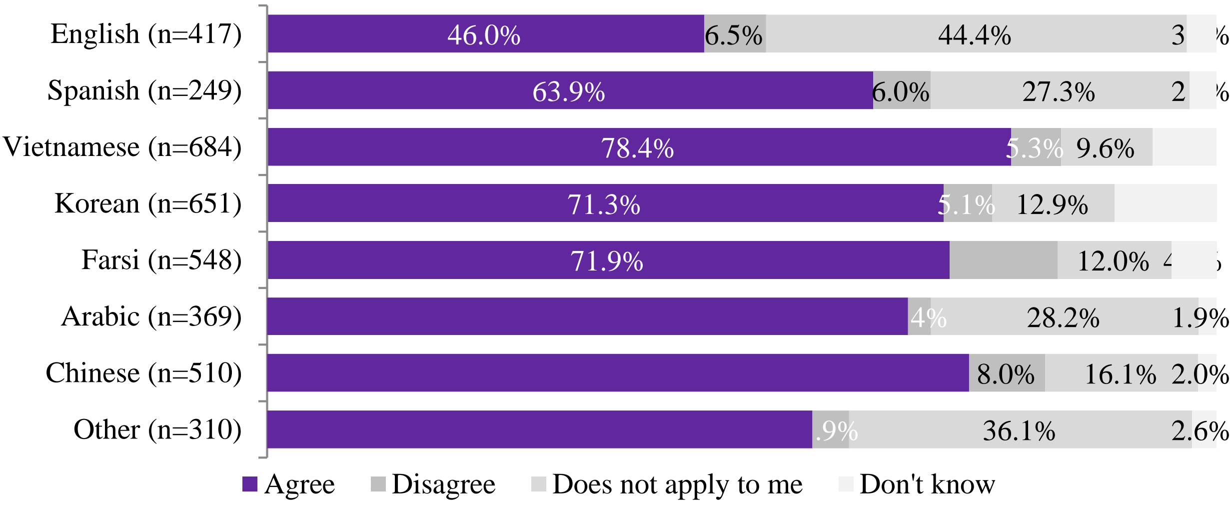



**Region:**



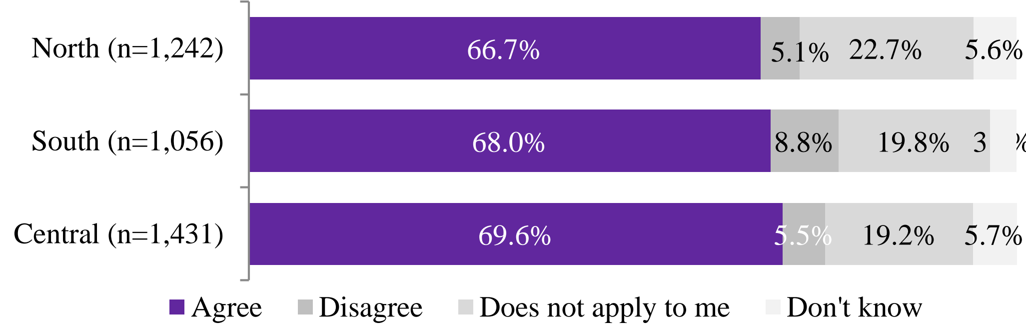
**Feel child respects them as a parent[9]:**

**CalOptima language:**




**Age Category:**

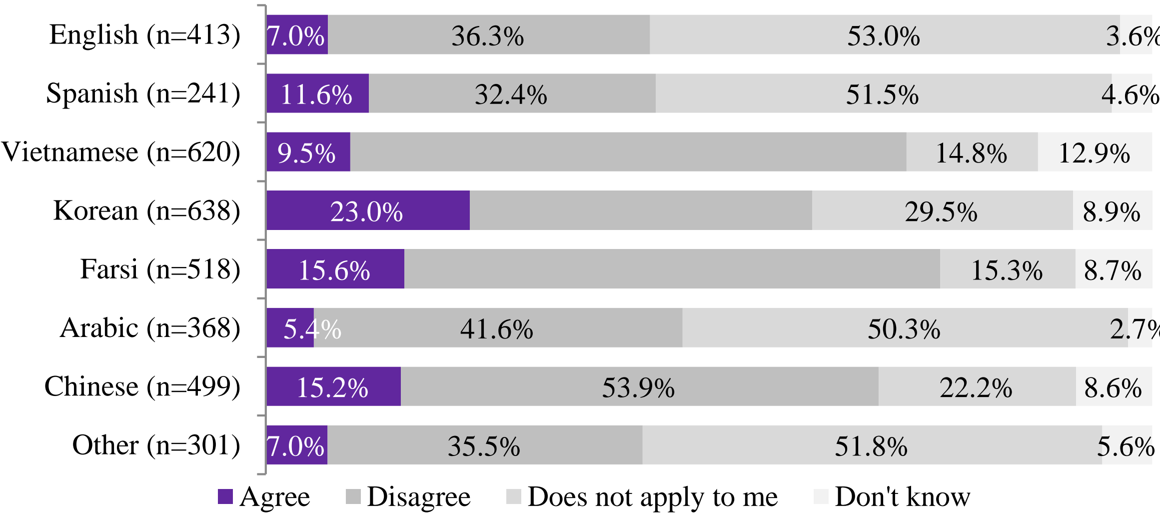
**Region:**



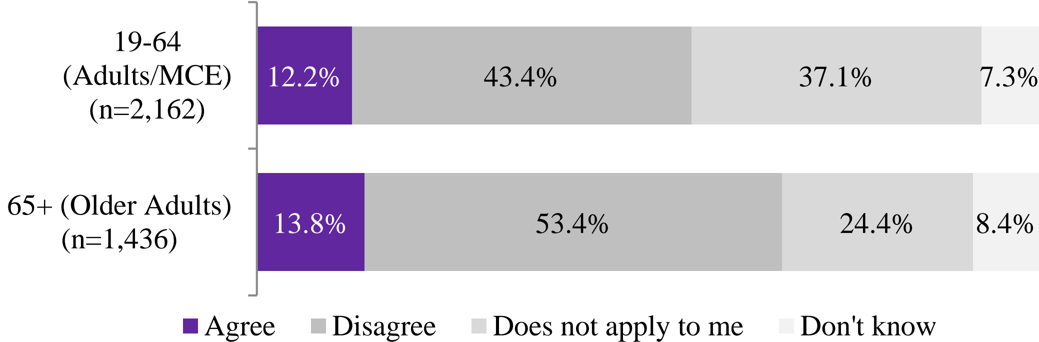

9 Only reported those who are over 18 years old.

**Feel child's attitudes and behavior conflict with cultural values[10]:**

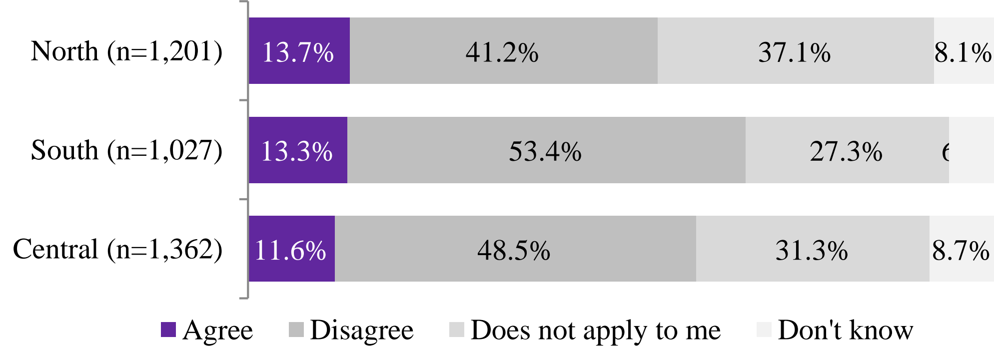
**CalOptima language:**




**Age Category:**



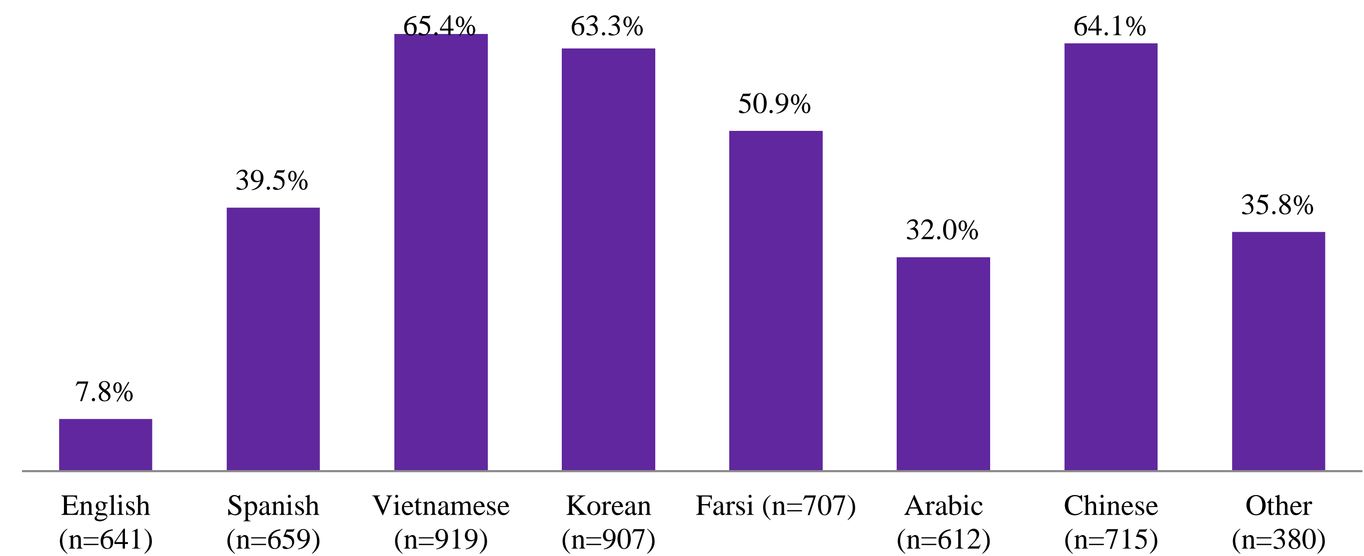

**Region:**



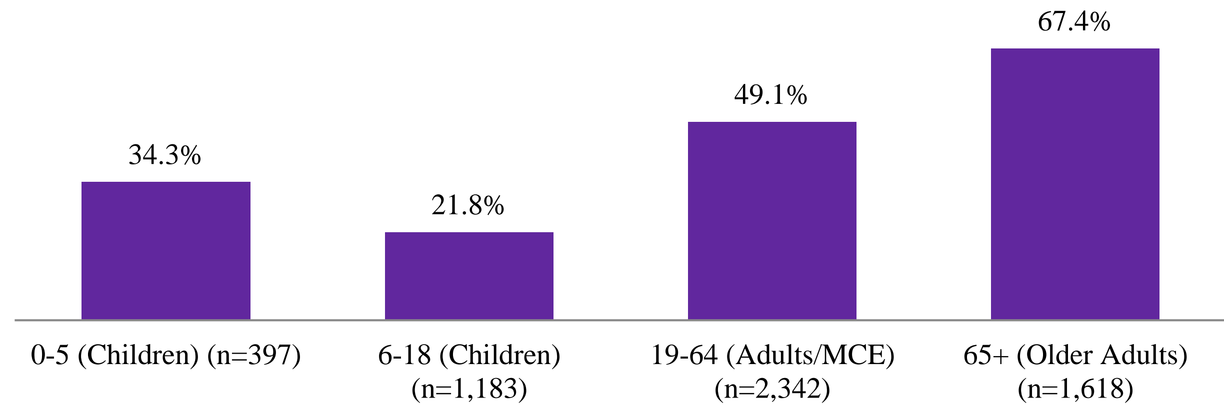

[10] Only reported those who are over 18 years old.

**Exhibit 17. Members who reported that they speak English "not well":**

**CalOptima language:**




**Age Category:**




**Region:**

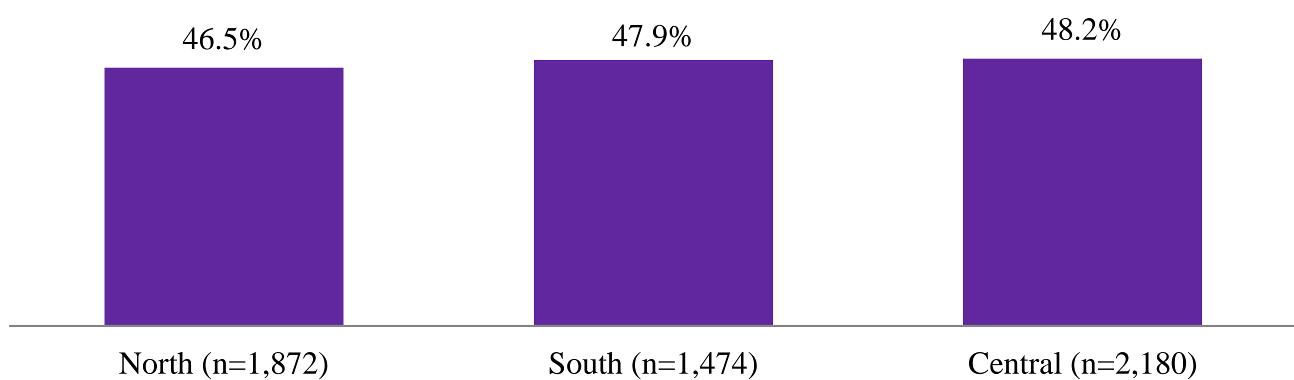


**Exhibit 18. Employment status[11,12]**

**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:**

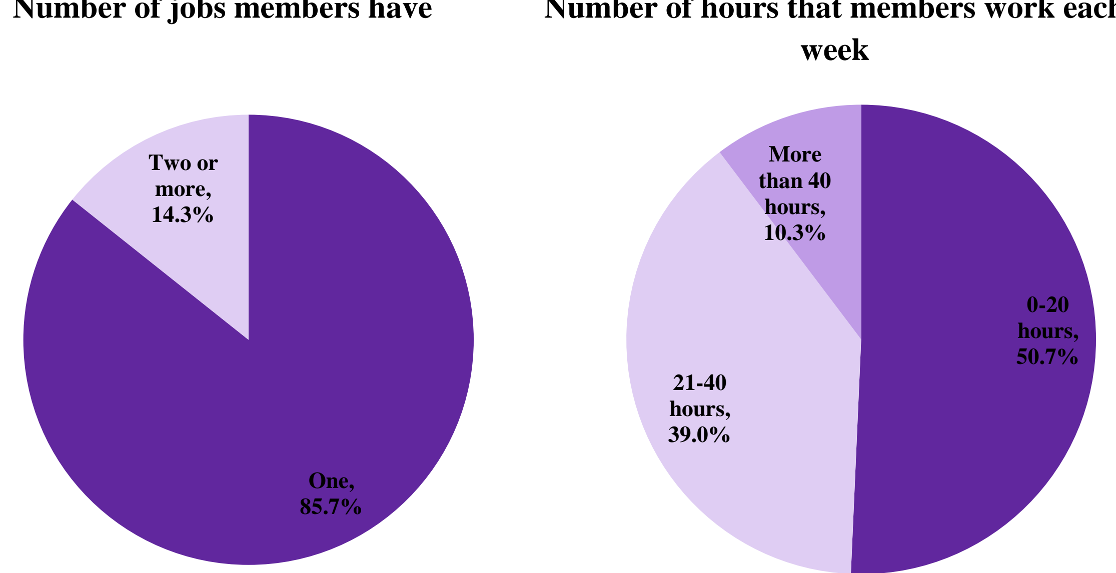
| Age Category | Employed % | Self employed % | Homemaker % | Student % | Retired % | Out of work % | Unable to work % | n |
|---|---|---|---|---|---|---|---|---|
| **19-64 (Adults/MCE)** | 35.8% | 8.3% | 17.5% | 10.9% | 5.9% | 17.6% | 15.3% | 2,370 |
| **65+ (Older Adults)** | 4.1% | 1.7% | 10.1% | 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 |

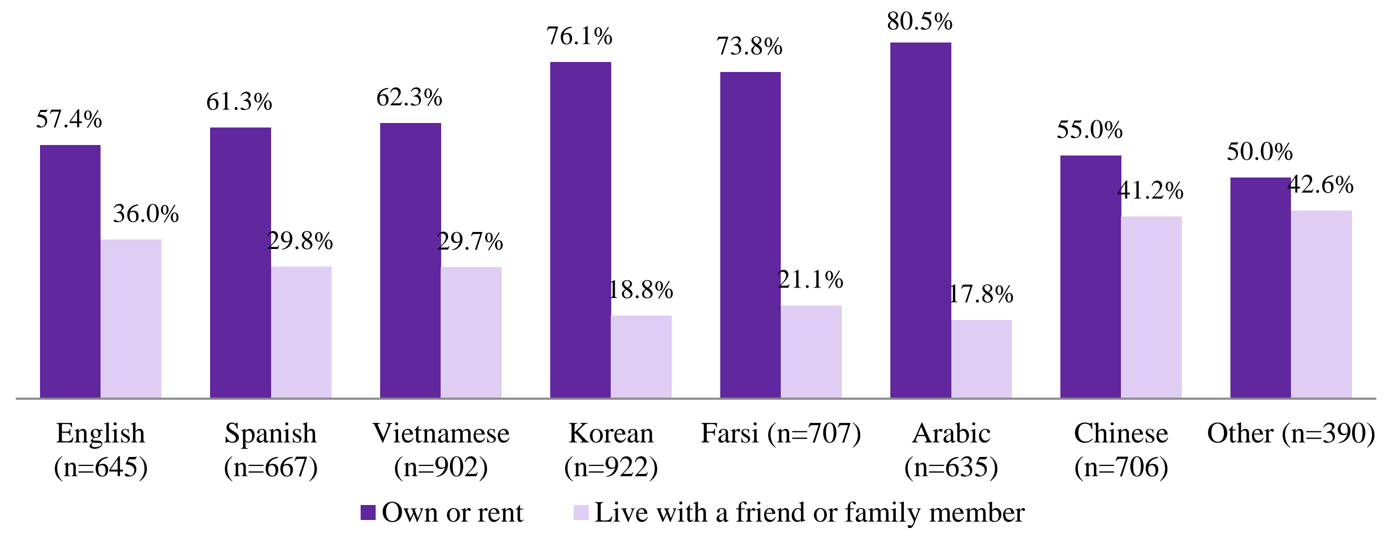
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

**Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]**

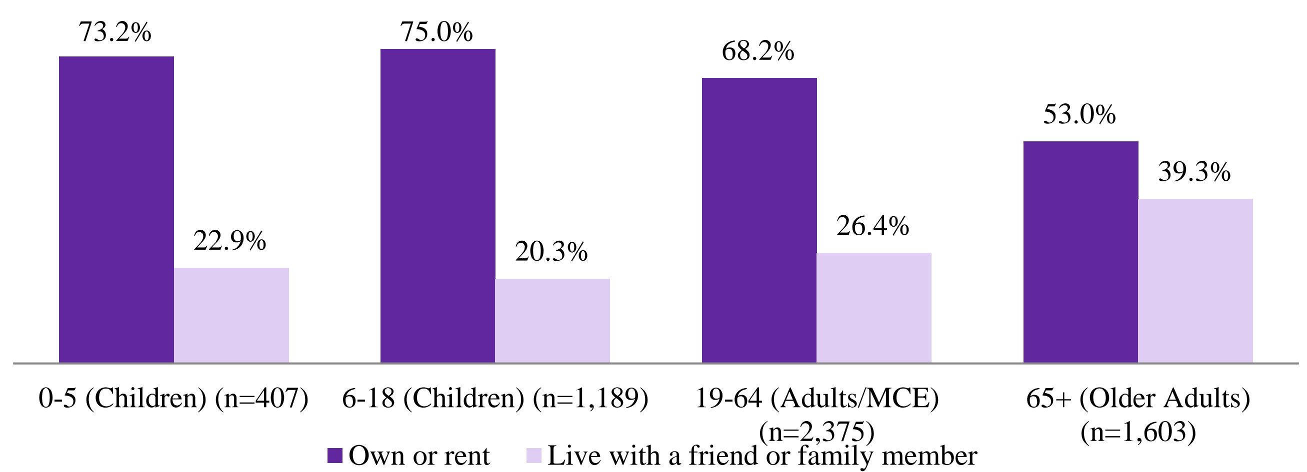



[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

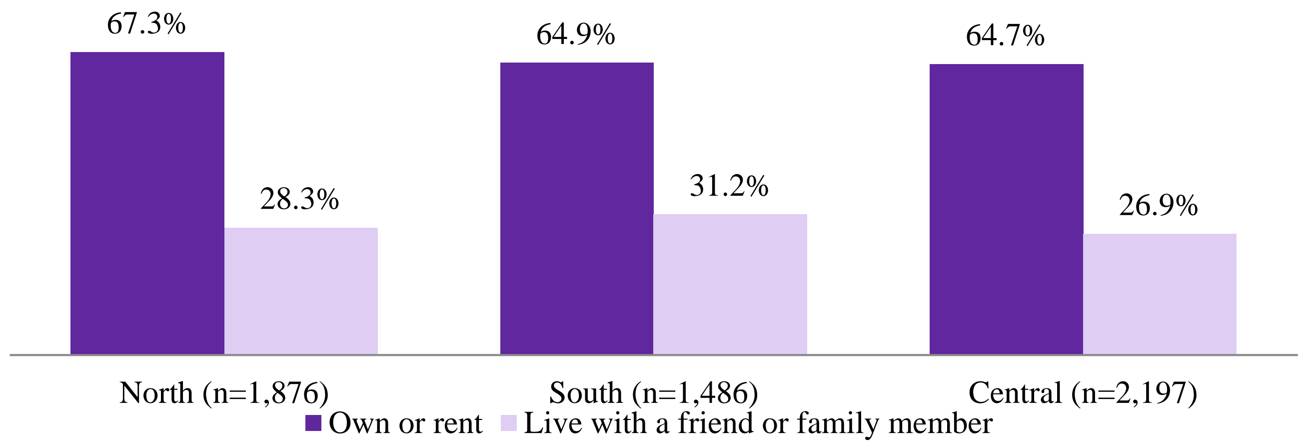
**Exhibit 20. Members' living situation[14]**




**Age Category:**



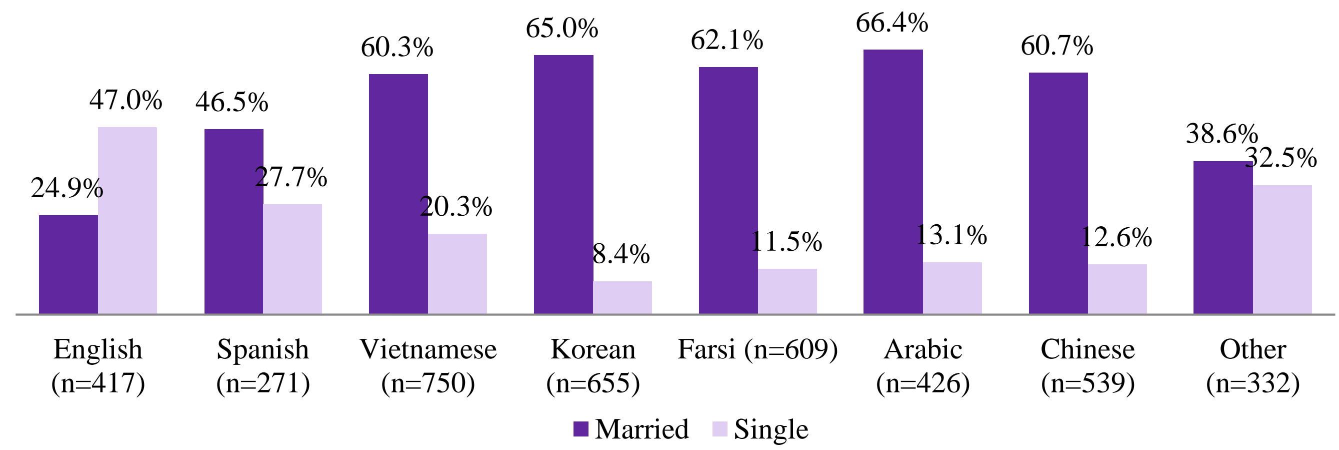

**Region:**



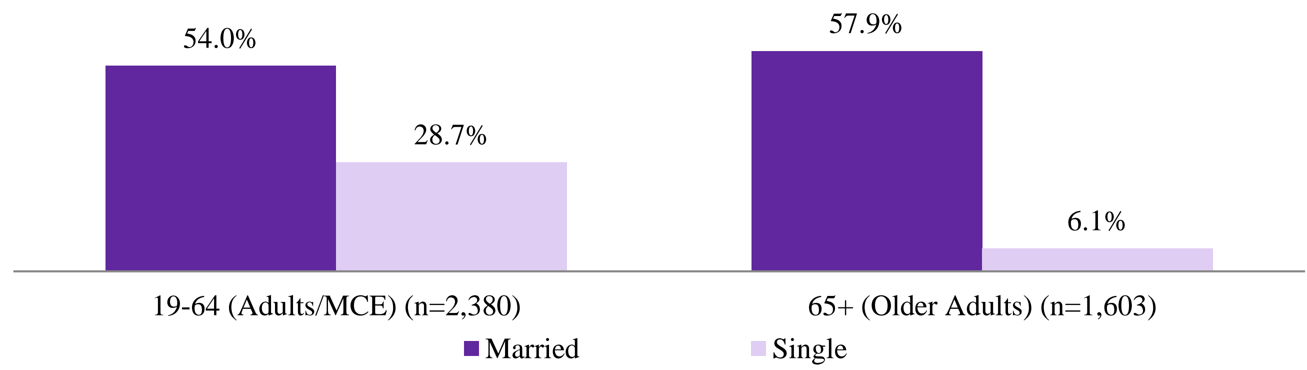

[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

**Exhibit 21. Marital status of members[15],[16]**

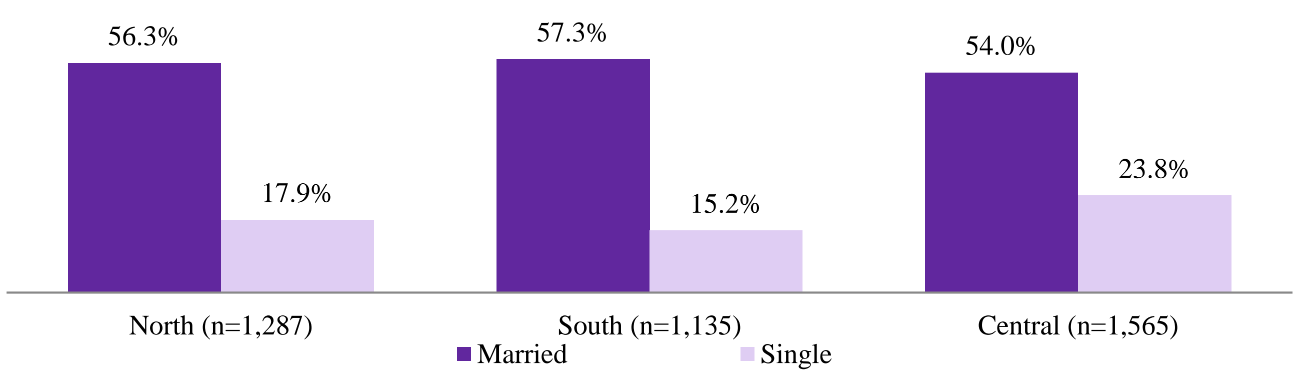
**CalOptima language:**




**Age Category:**



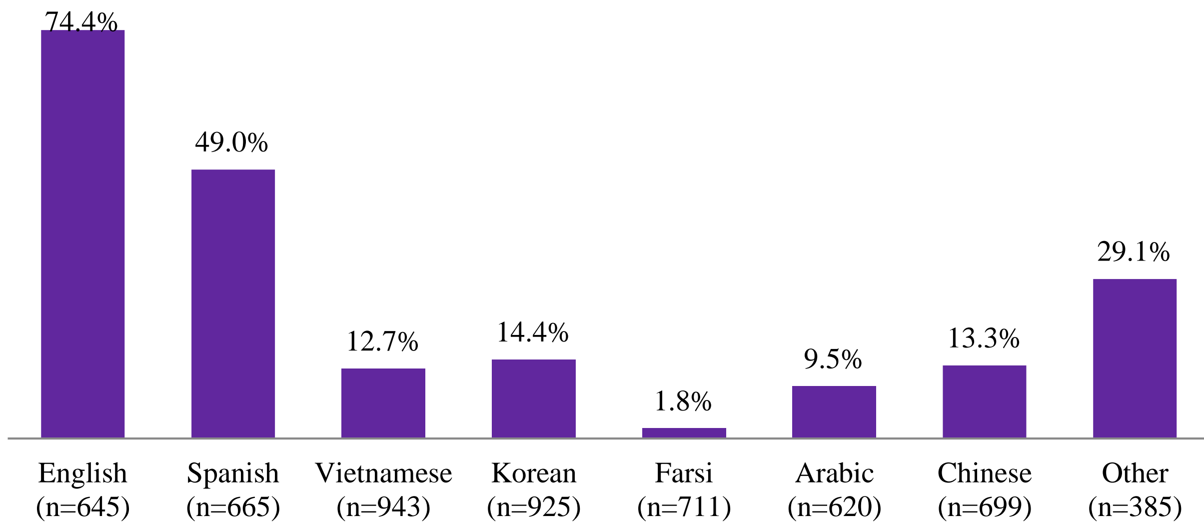

**Region:**



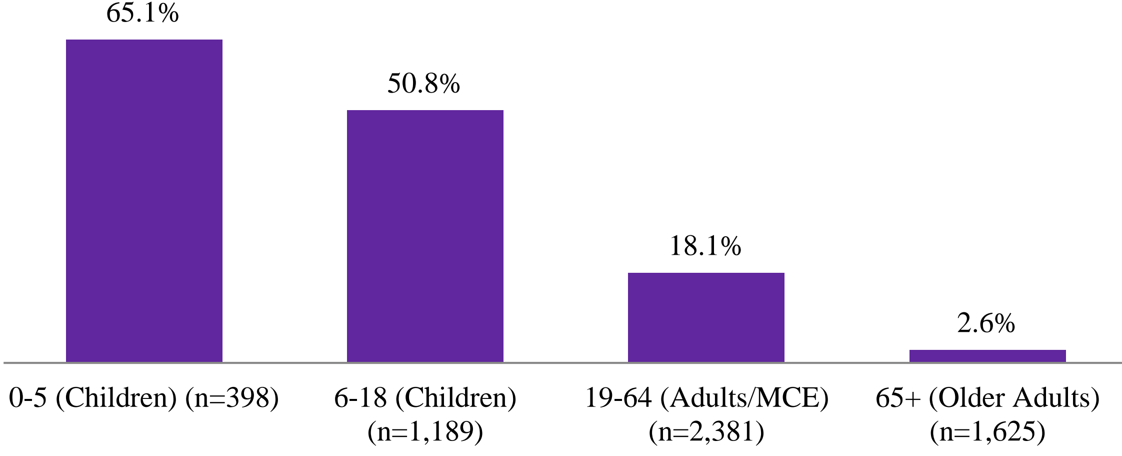

[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

**Exhibit 22. Percent of members who were born in the United States:**

**CalOptima language:**




**Age Category:**




**Region:**

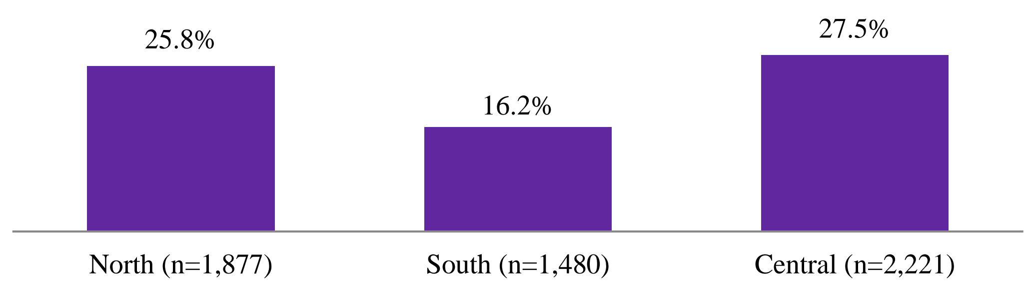
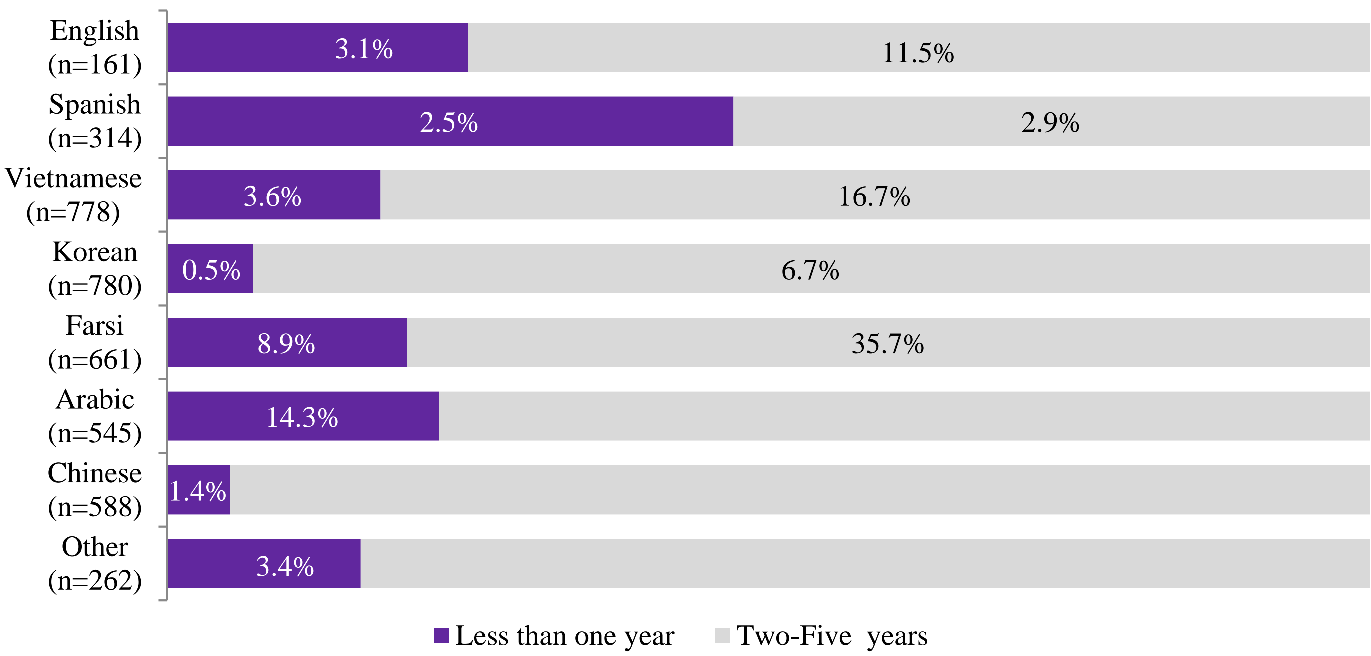
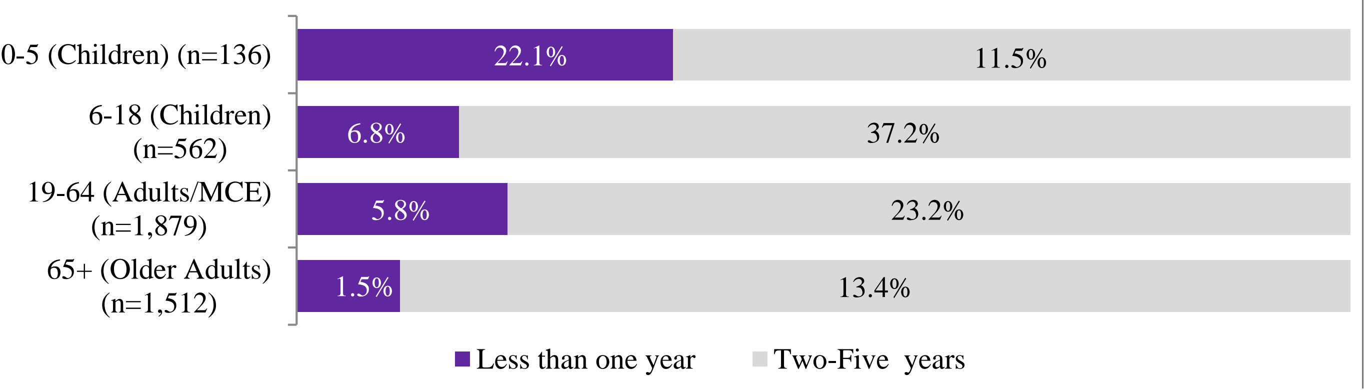


**Exhibit 23. Length of time lived in the United States of those not born in the United States**

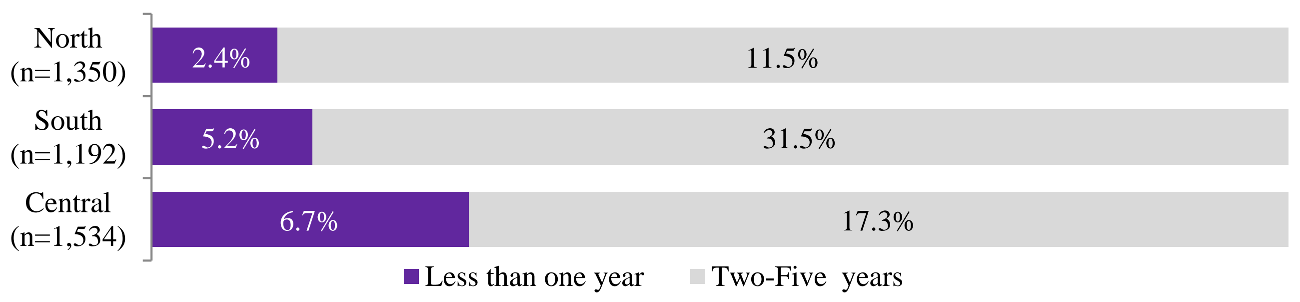
**CalOptima language:**




**Age Category:**




**Region:**





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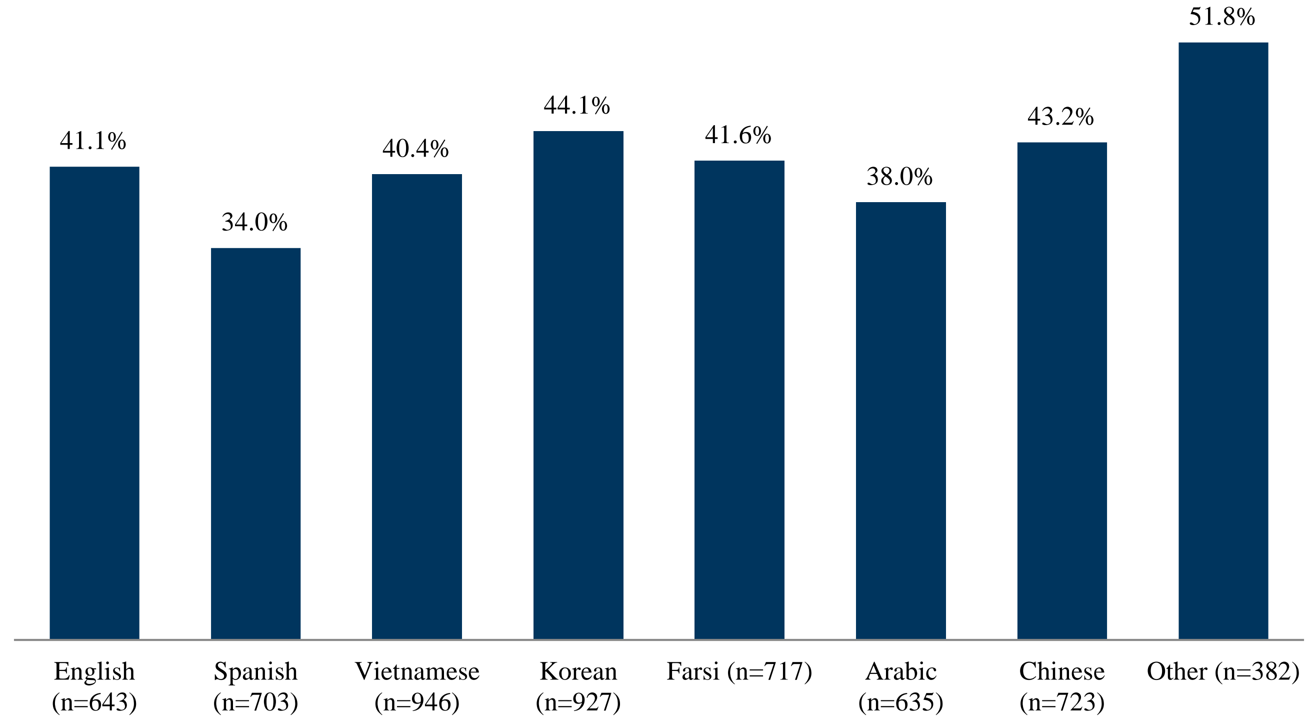
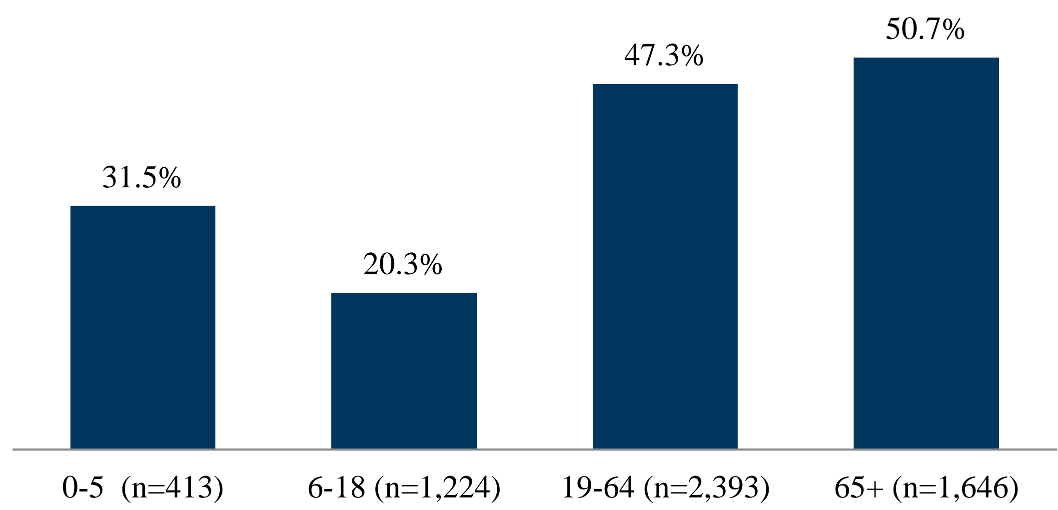
# Health Behaviors

**Exhibit 24. Percent of members who have not seen a dentist within the past 12 months**

**CalOptima language:**




**Age Category:**



**Region:**

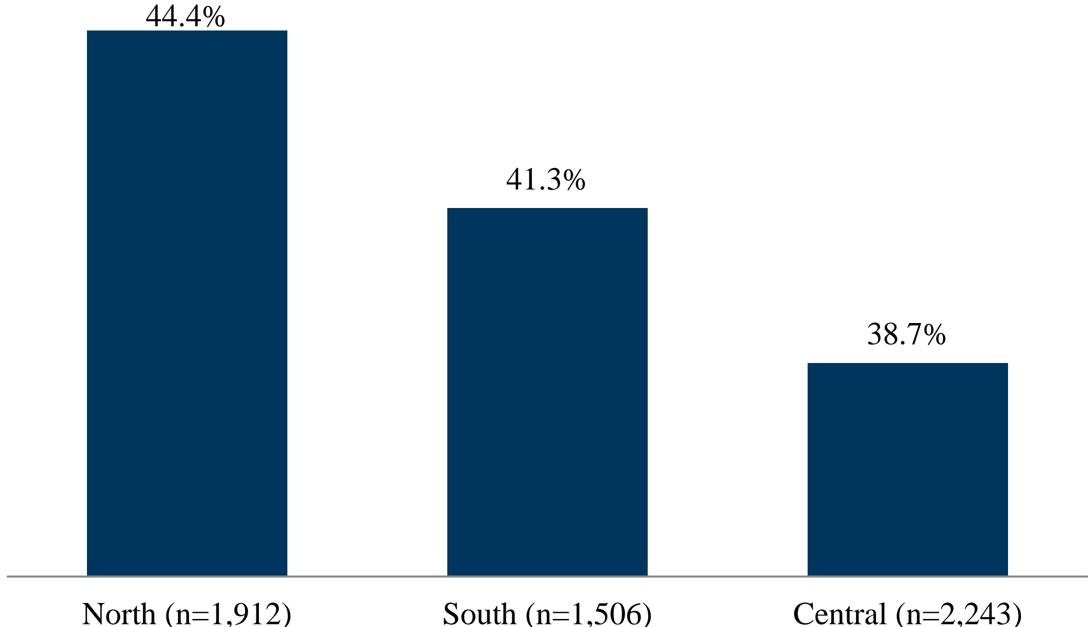


**Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]**

**CalOptima Language:**

| CalOptima Language | Cost<br>% | Don't have/know dentist<br>% | No transportation<br>% | Don't know<br>% | 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<br>% | Don't have/know dentist<br>% | No transportation<br>% | Don't know<br>% | 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<br>% | Don't have/know dentist<br>% | No transportation<br>% | Don't know<br>% | 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.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**Region:**

| CalOptima Region | No drinks in past 30 days<br>% | 1 2 days per week<br>% | 3 4 days per week<br>% | 5 7 days per week<br>% | Don't know<br>% | 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

# Navigating the Healthcare System

**Exhibit 27. Percent who report at least one person as their doctor (n=5,749)**

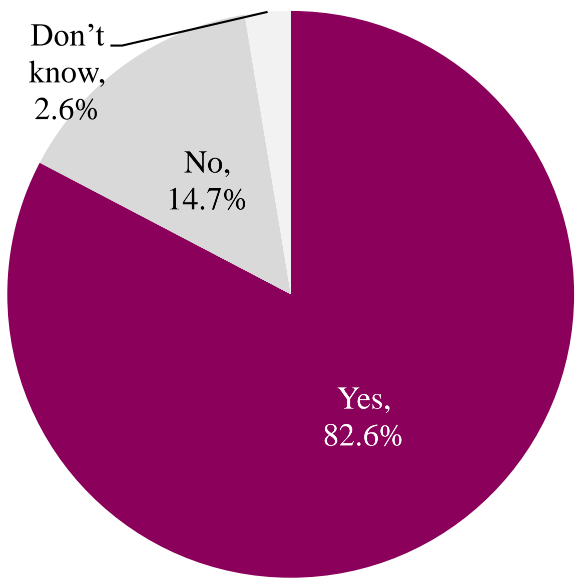



**Exhibit 28. Where respondents go to see their doctor (n=5,743)**

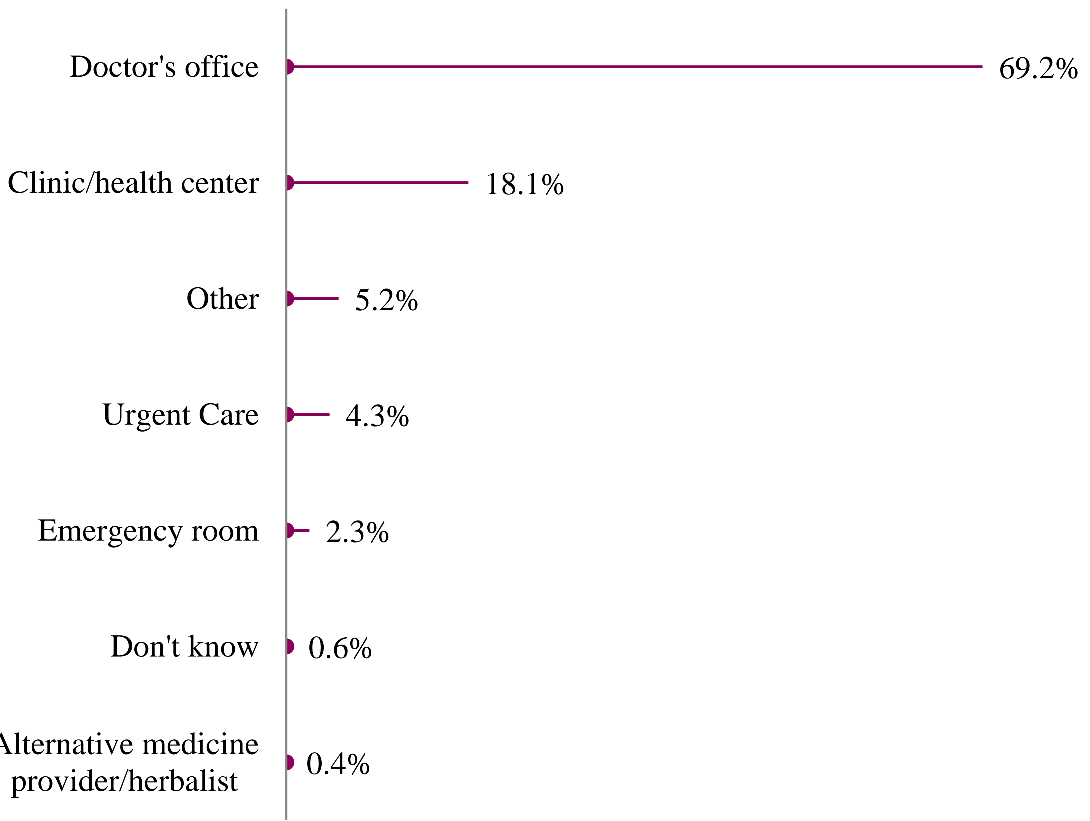


**Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)**

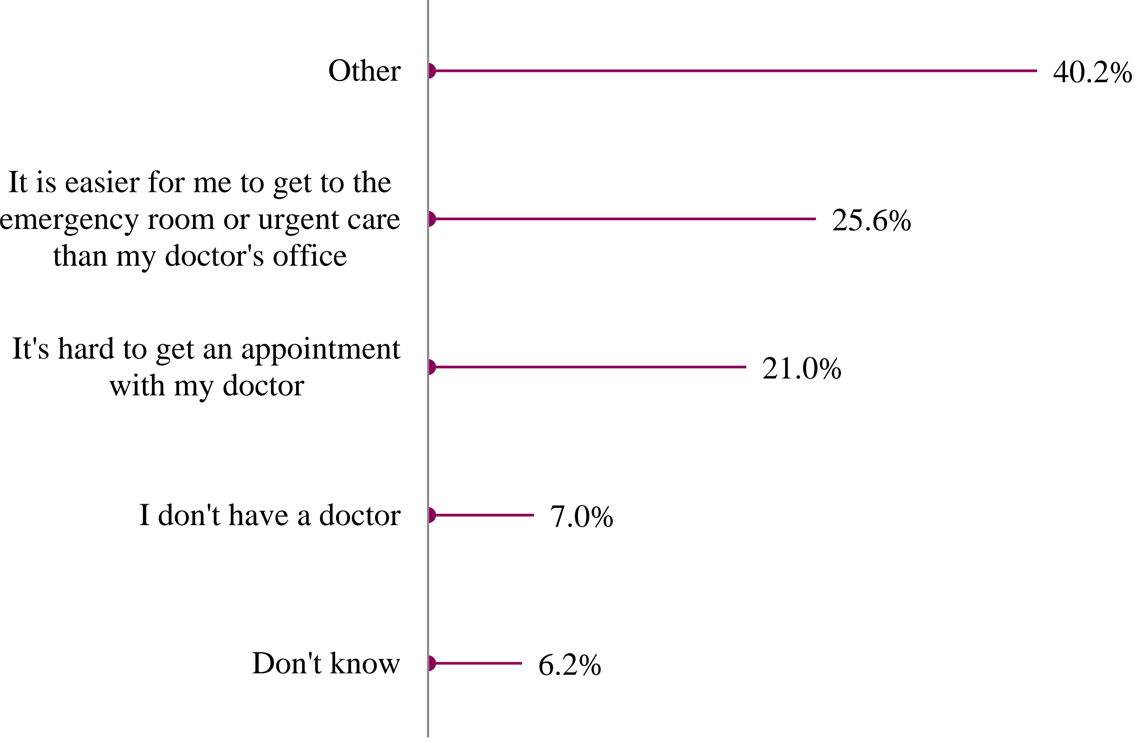


**Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]**

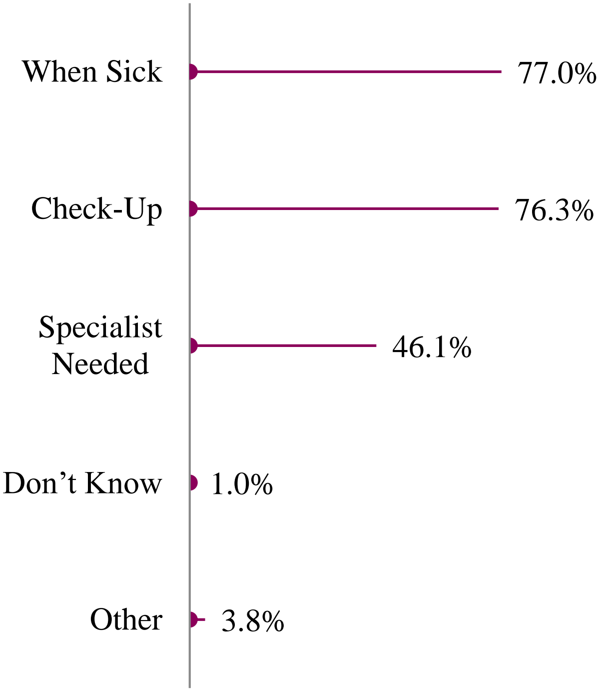
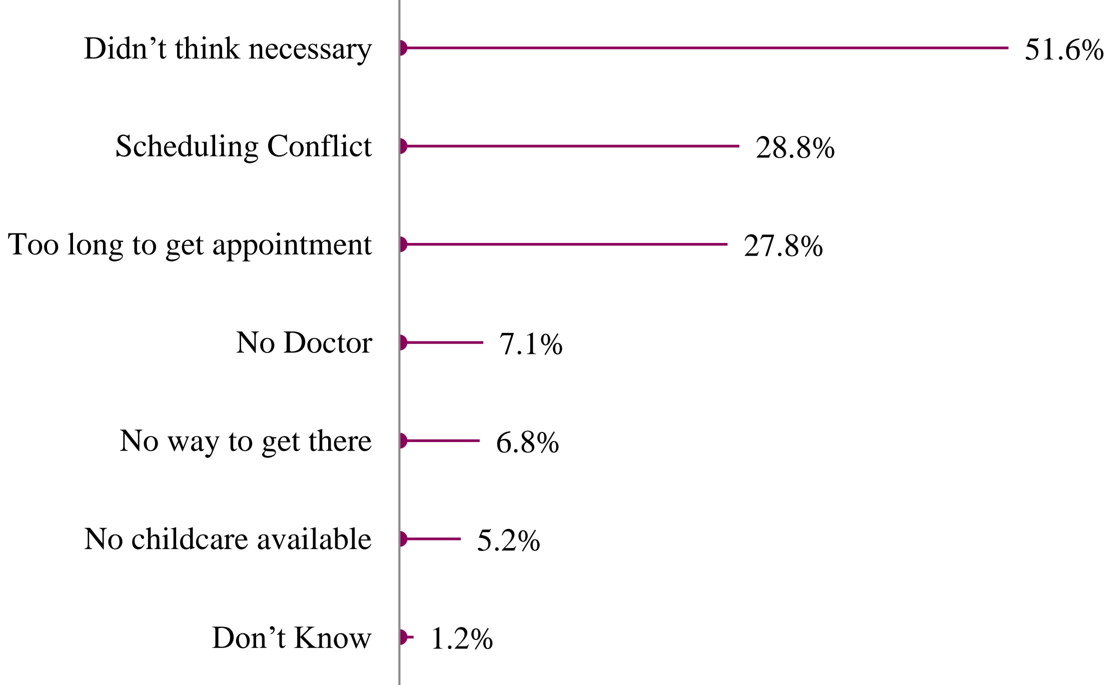



**Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]**




[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%.



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**Exhibit 32. When do members make an appointment to see a specialist (n=5,590)[22]**

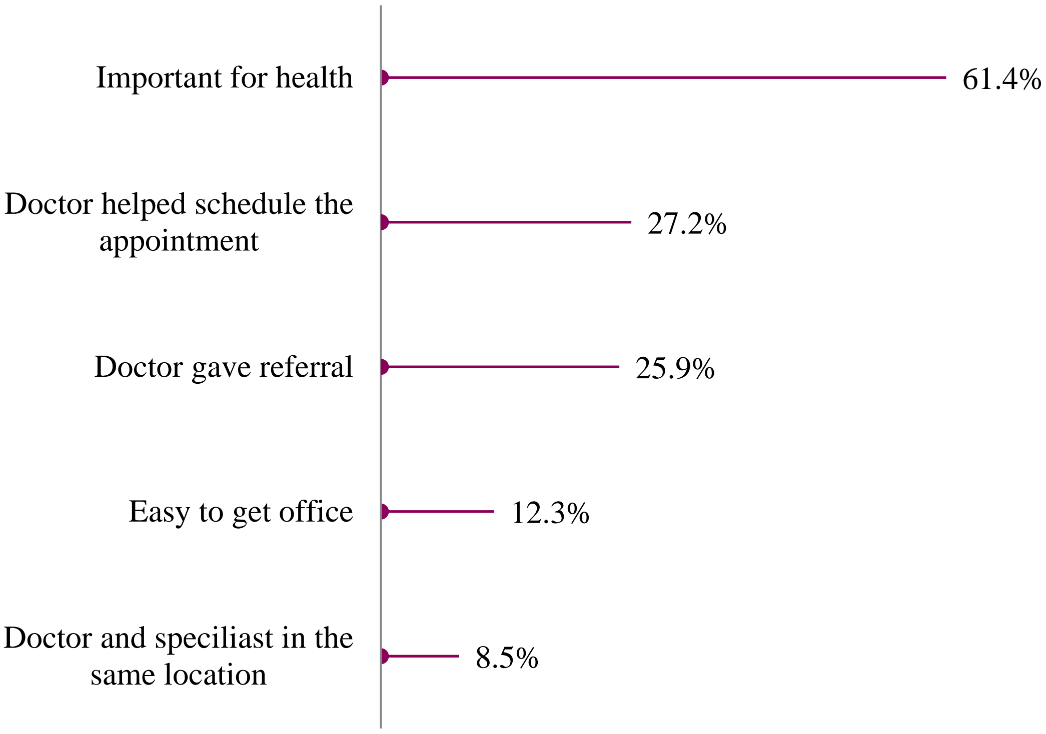
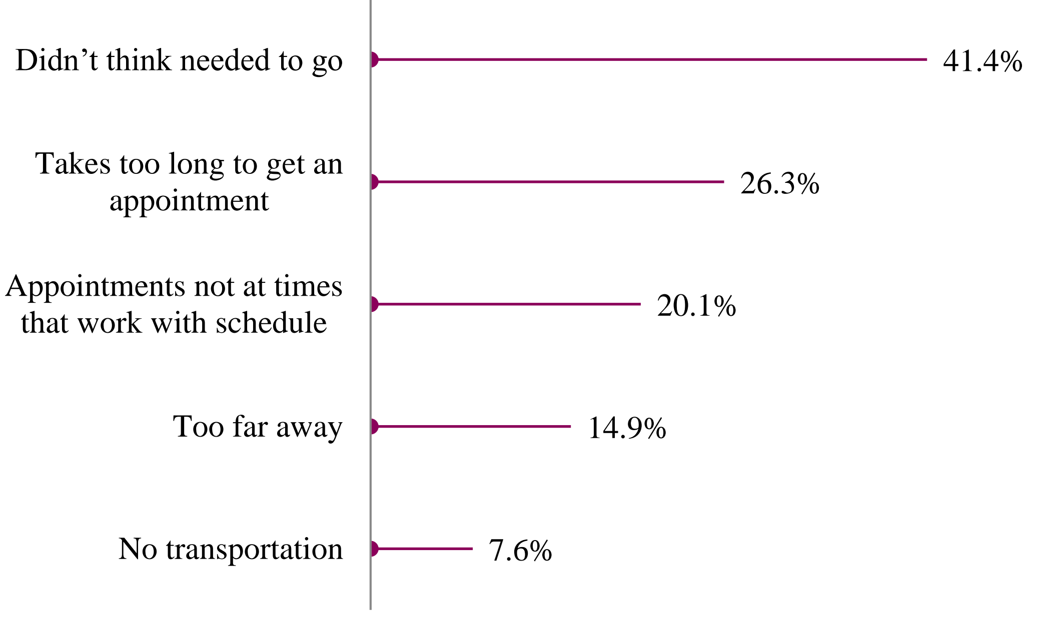


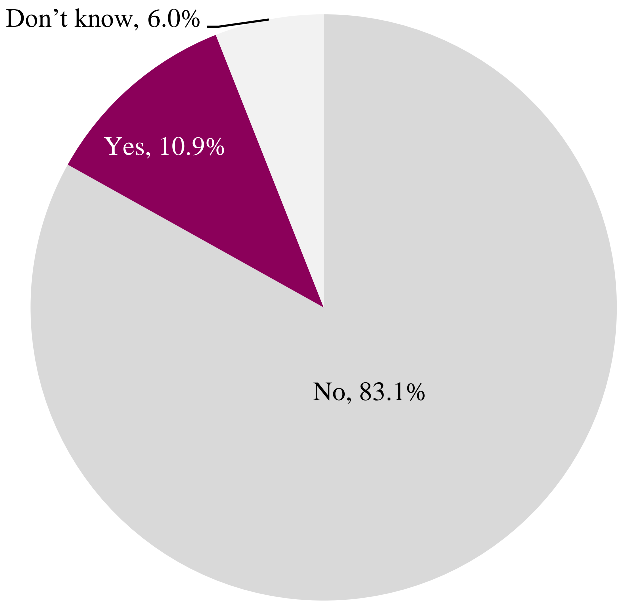

**Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]**




[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)**

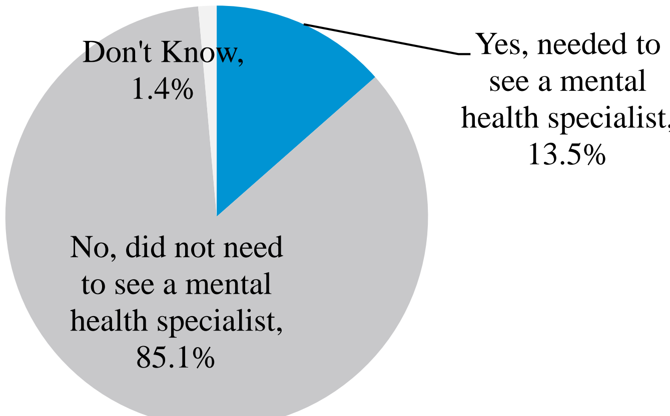



**Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)**

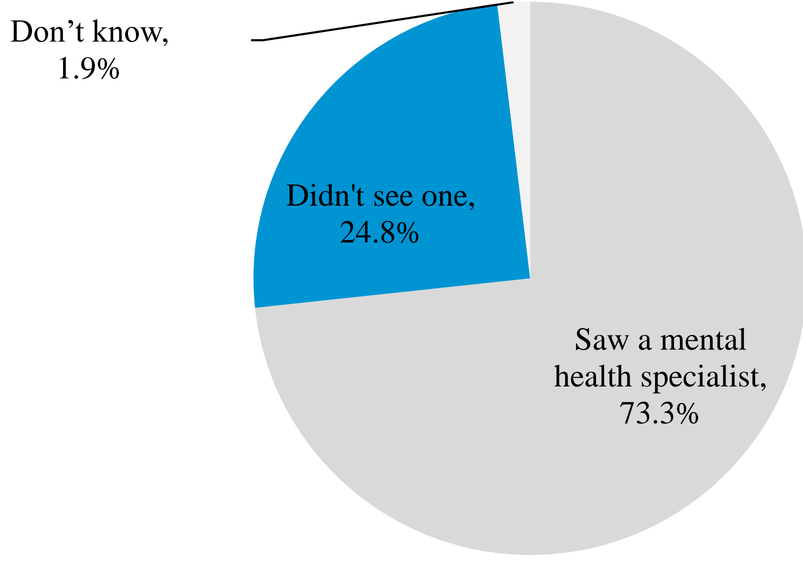


**Exhibit 37. Reasons why members didn't see mental health specialist[24]**

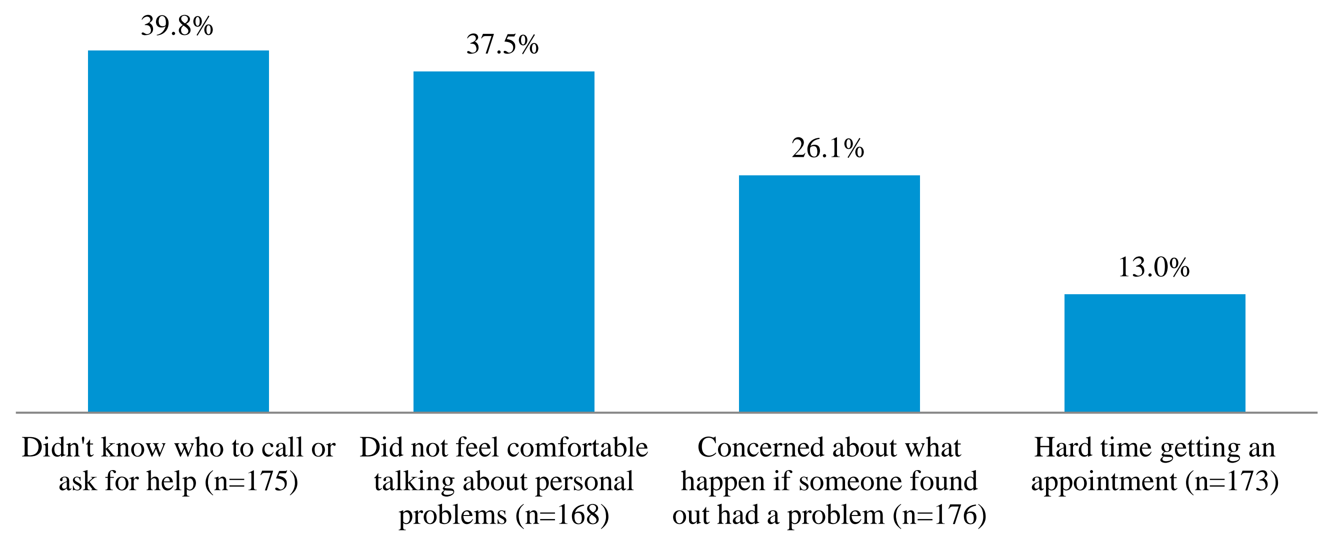
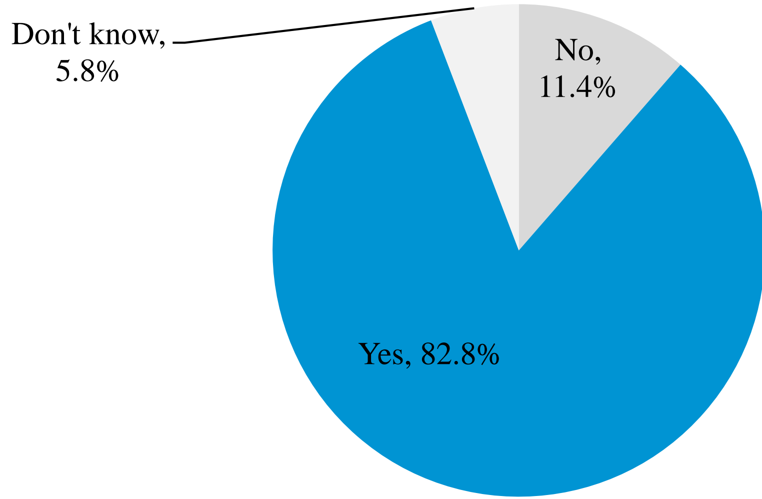



**Exhibit 38. Percent of members who can share their worries with family members (n=5,670)**




[24] Among those who indicated that they needed to see a mental health specialist but did not see one.



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# Social Determinants of Health

**Exhibit 39. Percent of members who needed help with basic needs in the past 6 months:**

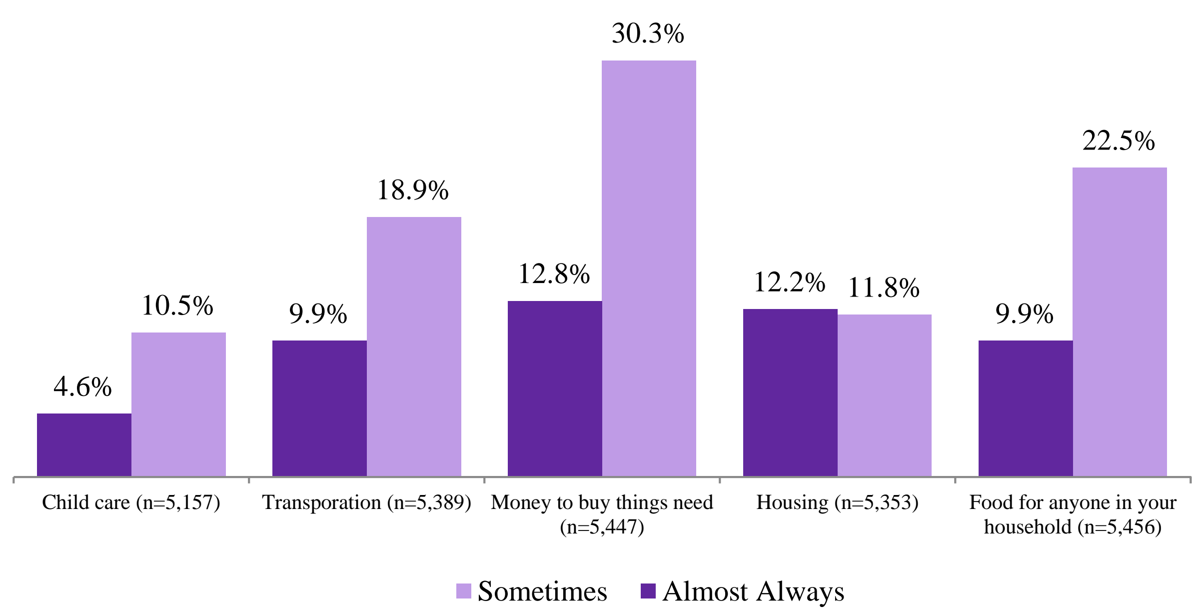


**Exhibit 41. Percent of members who receive public benefits (n=5,117):**

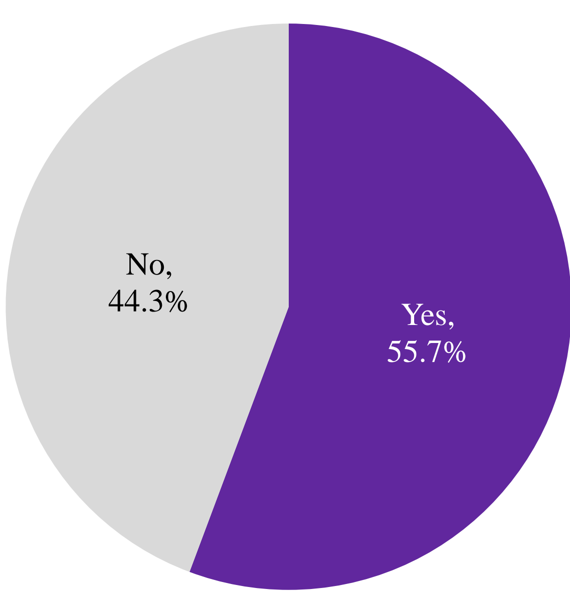
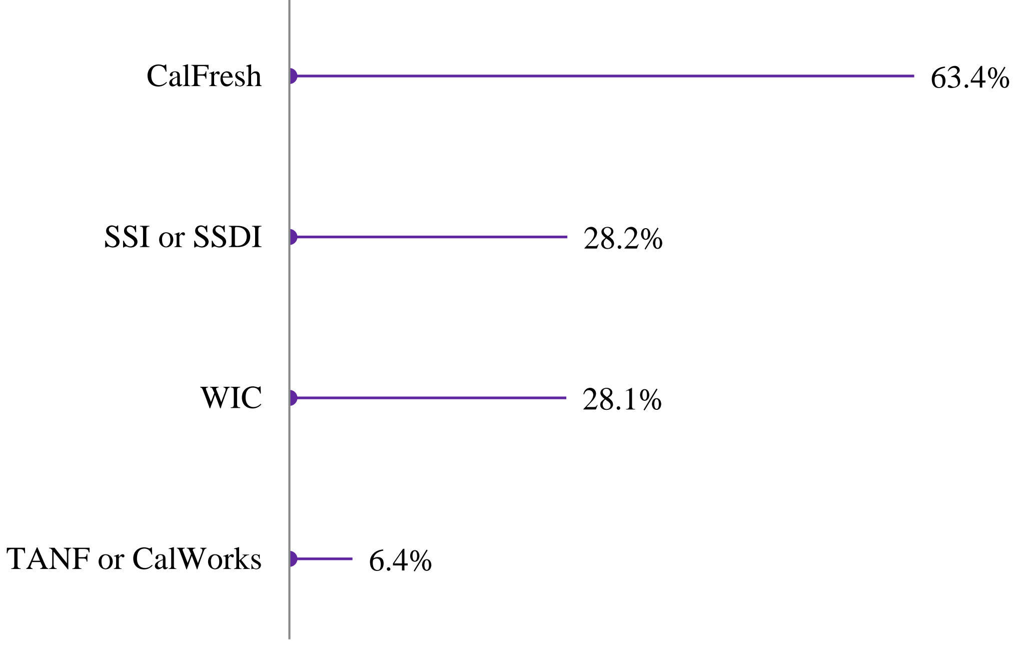



**Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:**




[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%.


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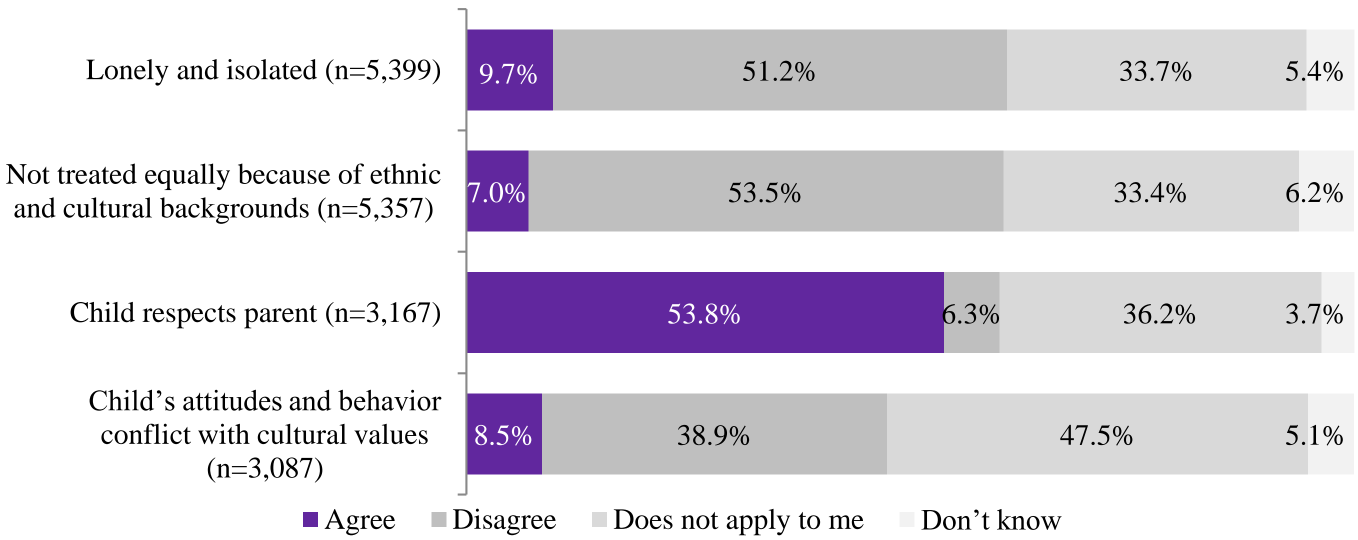
**Exhibit 43. Personal activities members participant in:**

| | 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)**

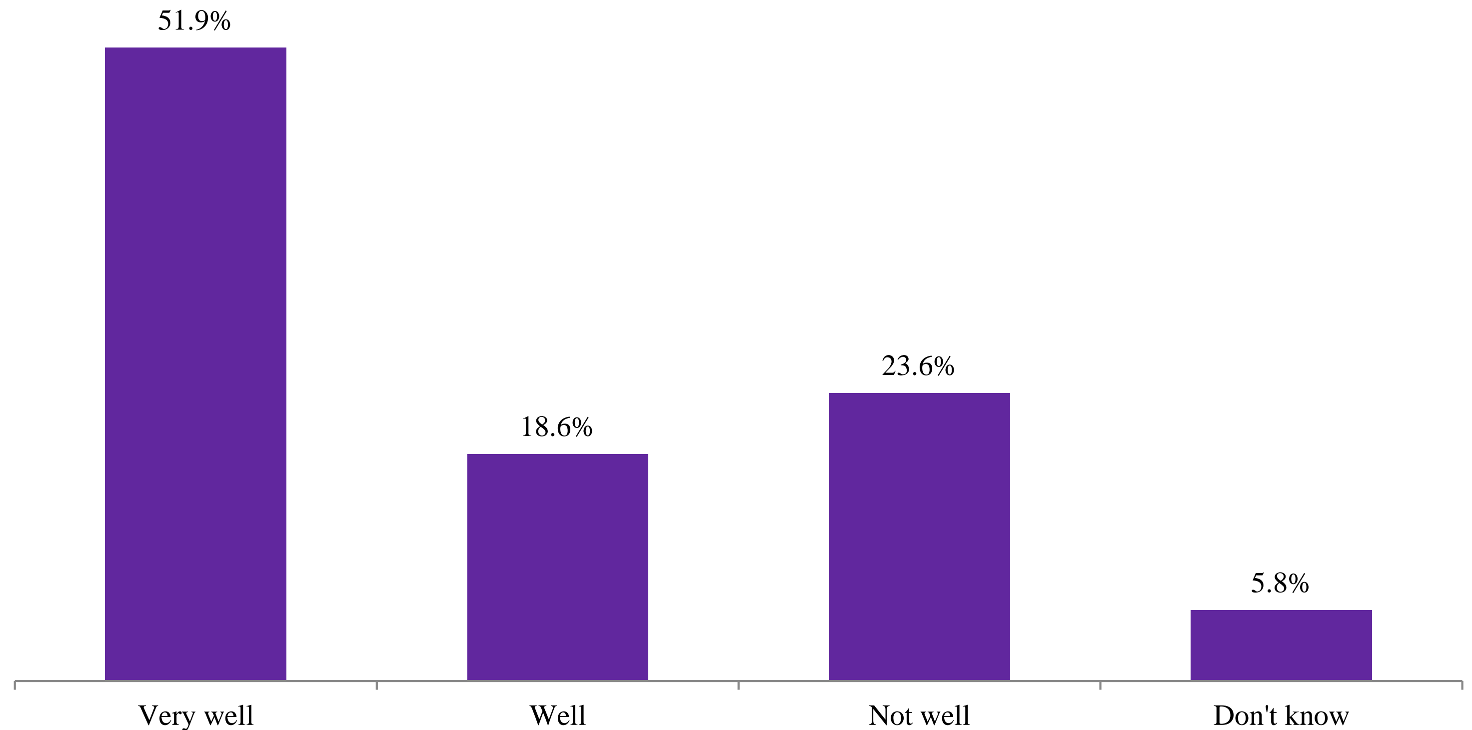


**Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]**

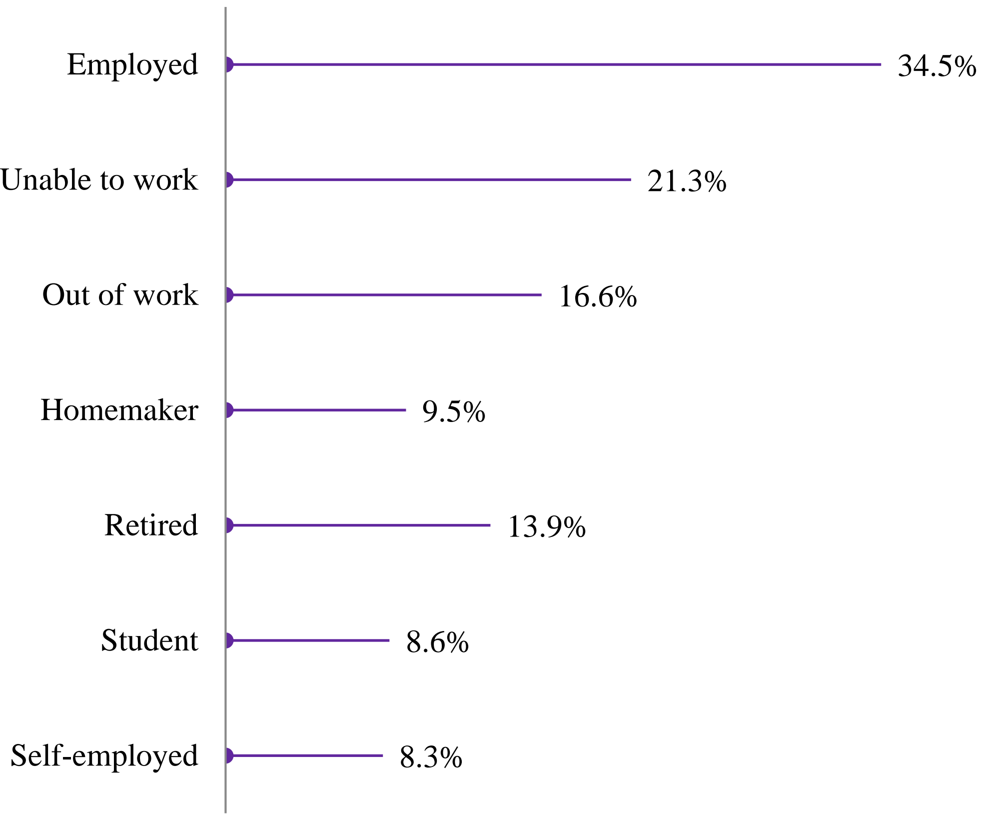
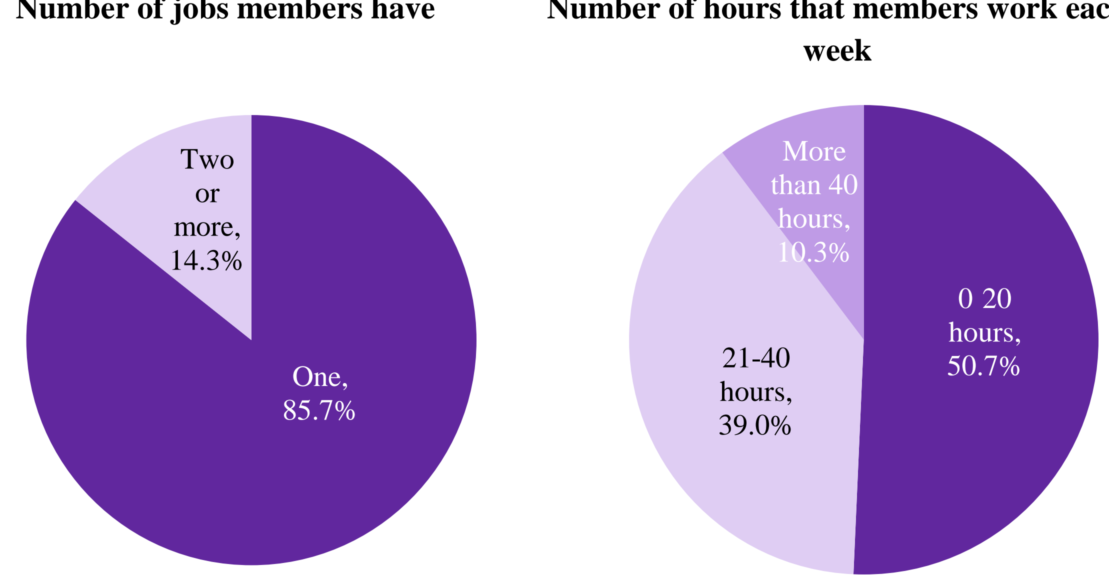



**Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]**




[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)**

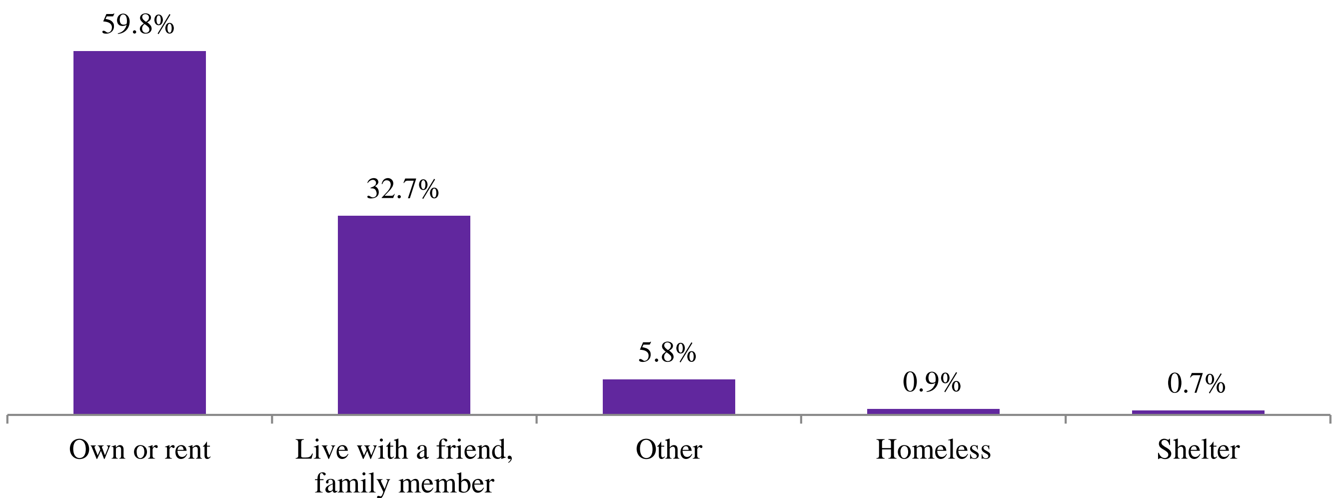
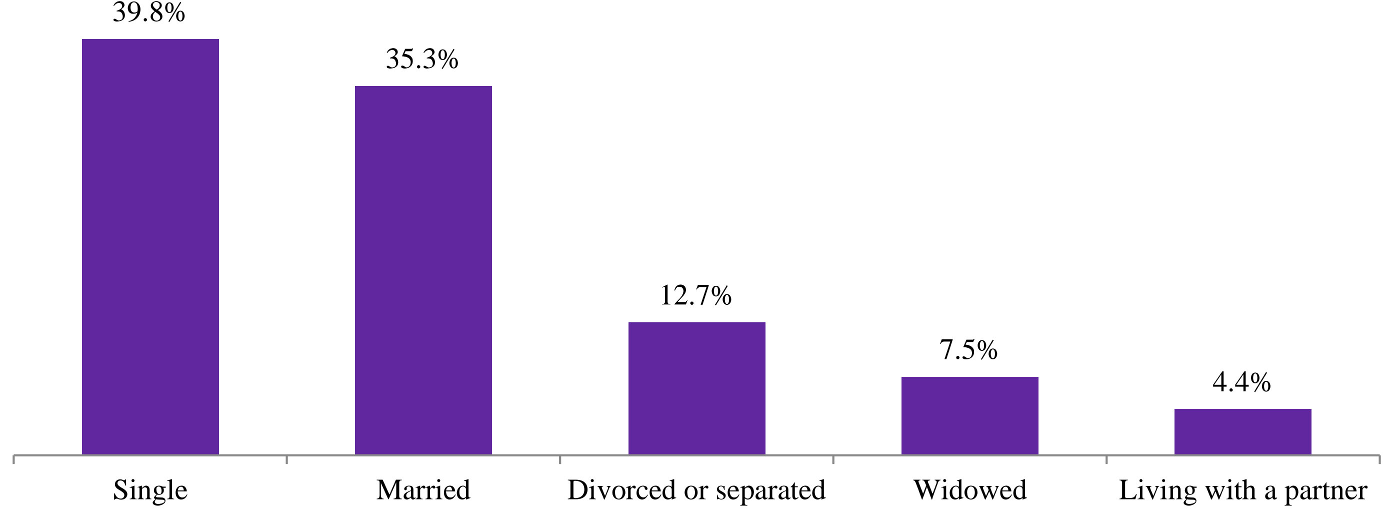



**Exhibit 49. Marital status of members (n=3,271)[30]**




[30] Only reported those who are over 18 years old.


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**Exhibit 50. Percent of members who were born in the United States (n=5,599)**

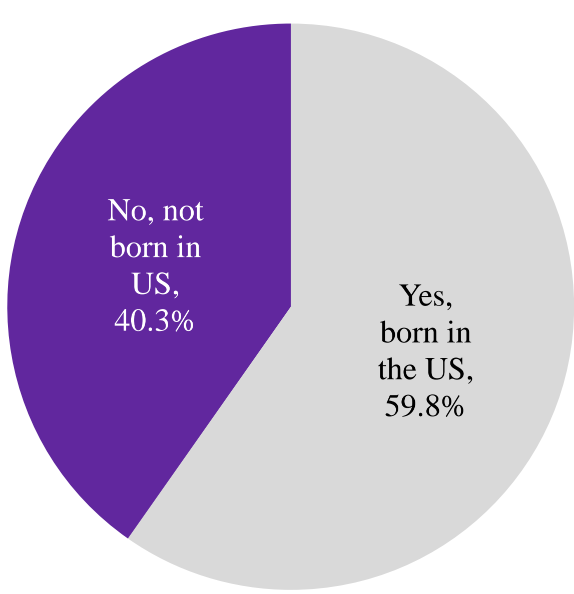
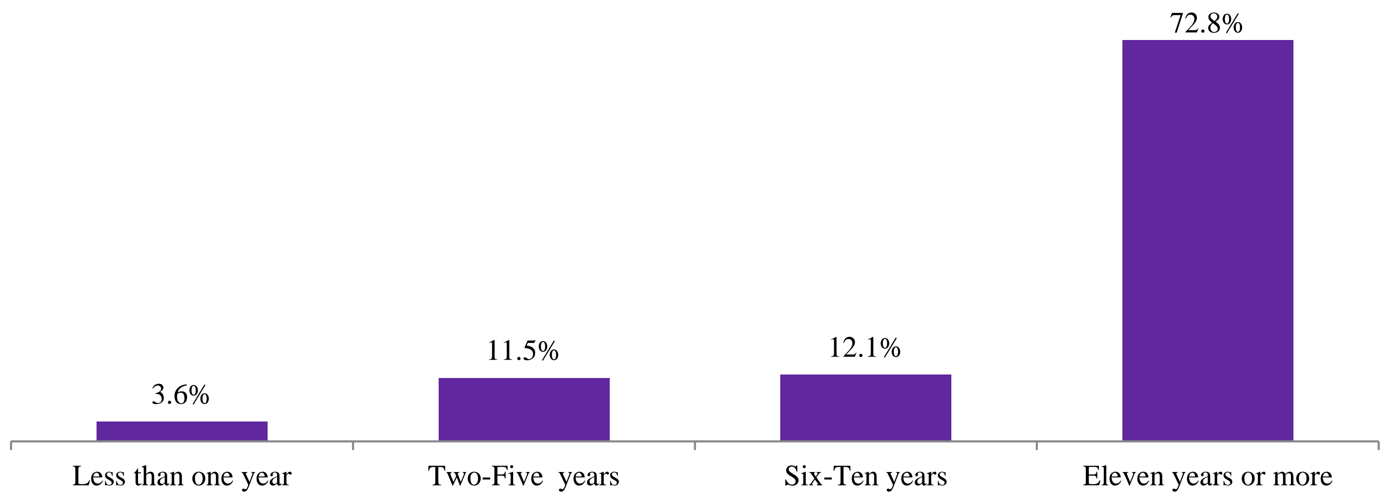



**Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]**




[31] Of those who were born outside of the U.S.

# Health Behaviors

**Exhibit 52. When members last saw a dentist (n=5,685)**

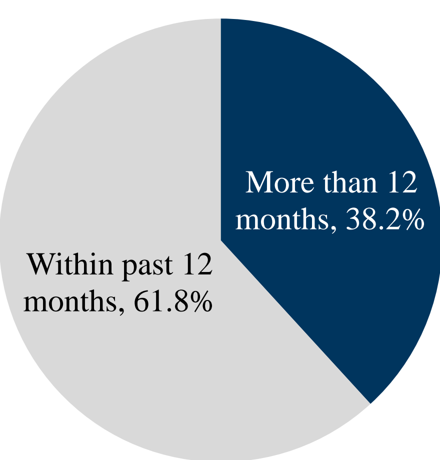
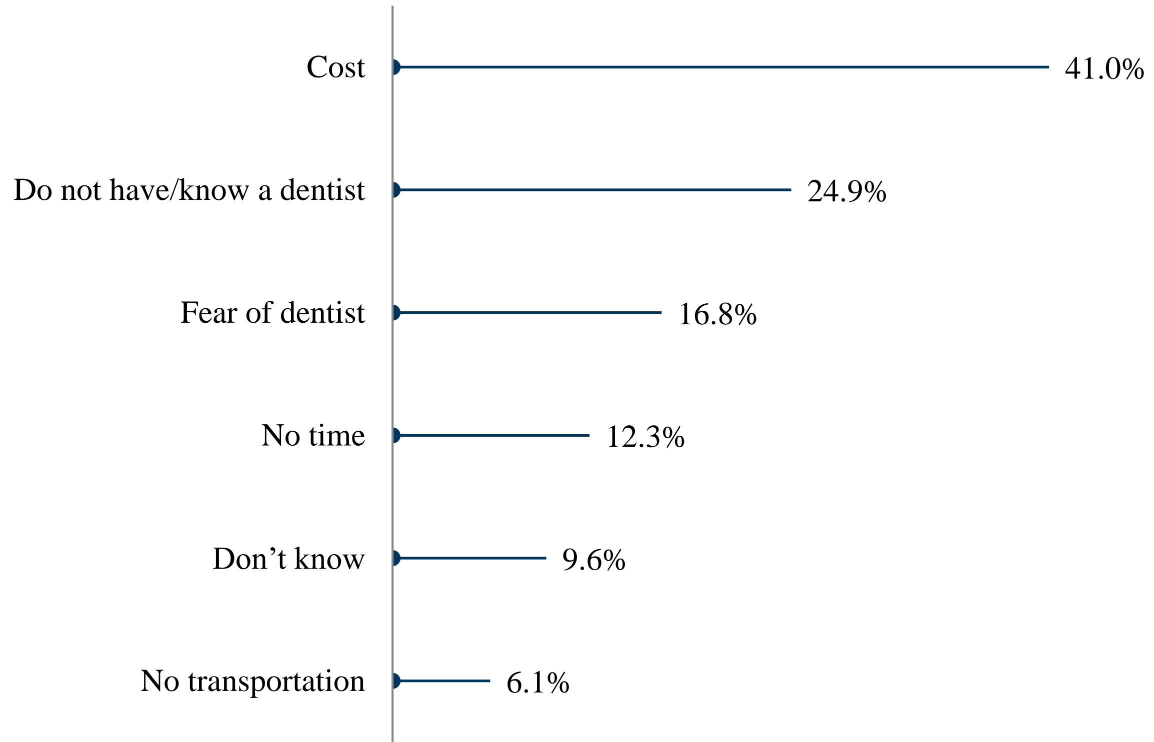


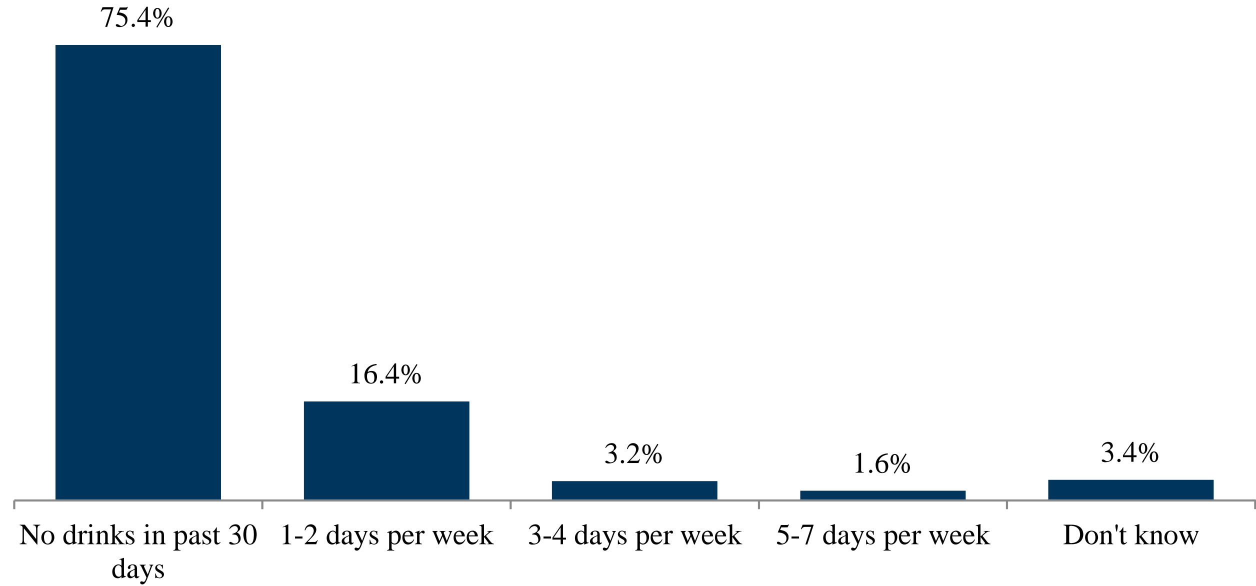

**Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]**




[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* *11/28/2018*
**Authorized Signature** **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 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

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

# 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

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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

# 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** |

# 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.

| # | 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.

**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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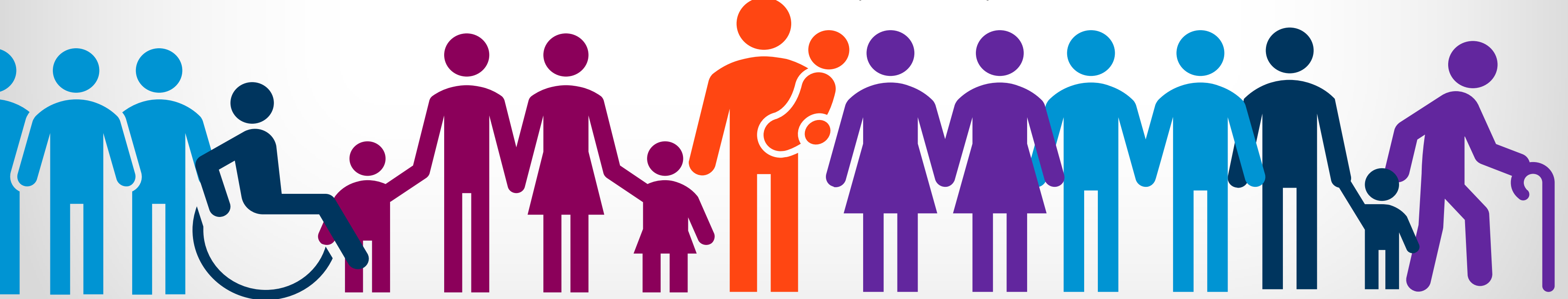
# More Comprehensive

- 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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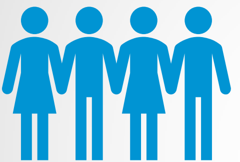
# More Engaging: Members



## 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

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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

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

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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.

**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

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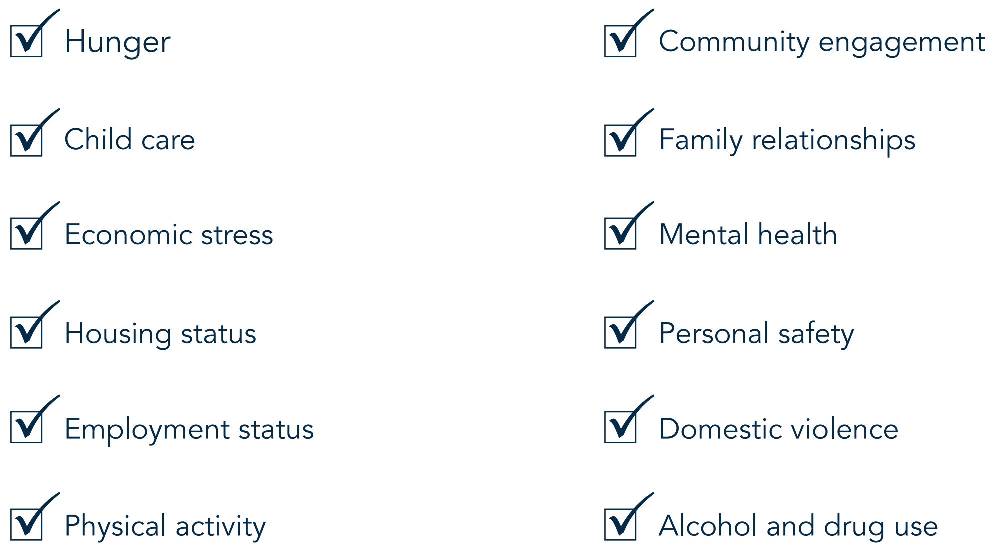
## More Comprehensive

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:




*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.

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## 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.

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**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)

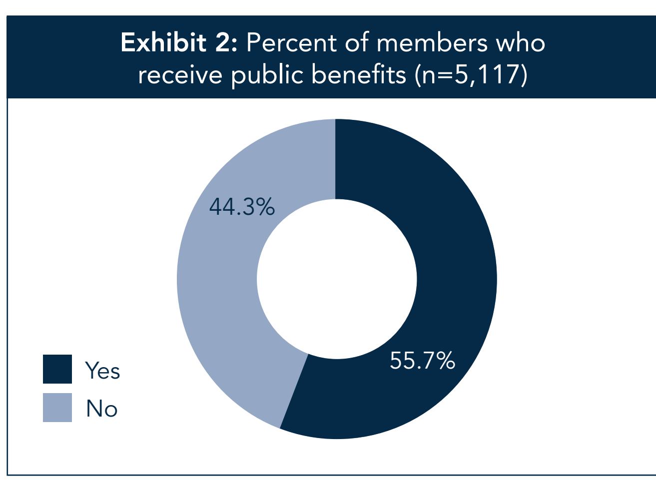
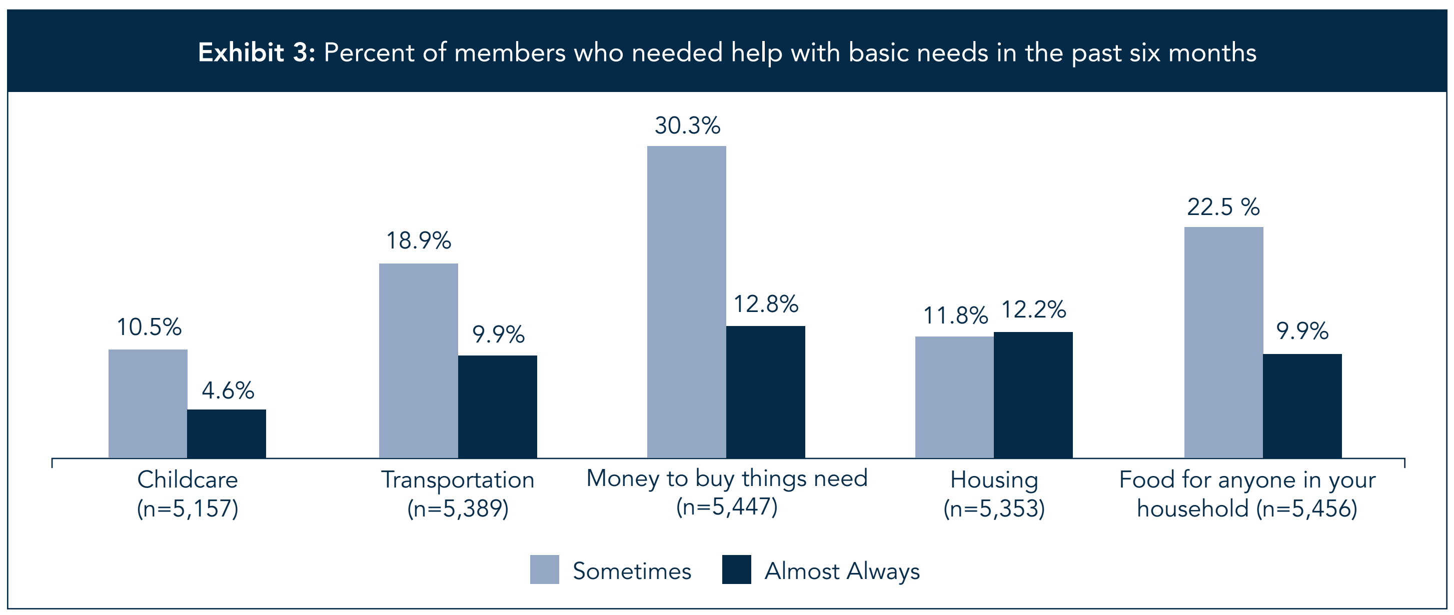
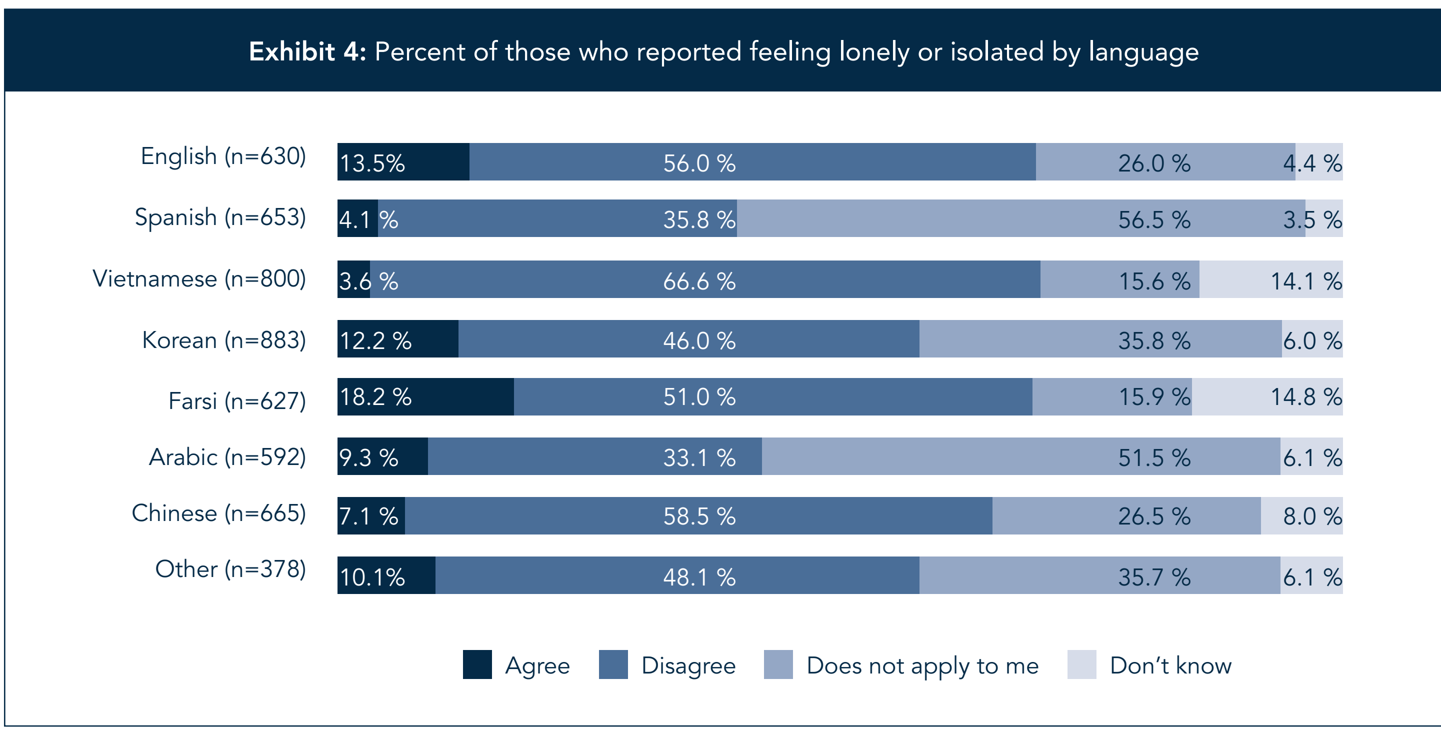



**Exhibit 3:** Percent of members who needed help with basic needs in the past six months



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)

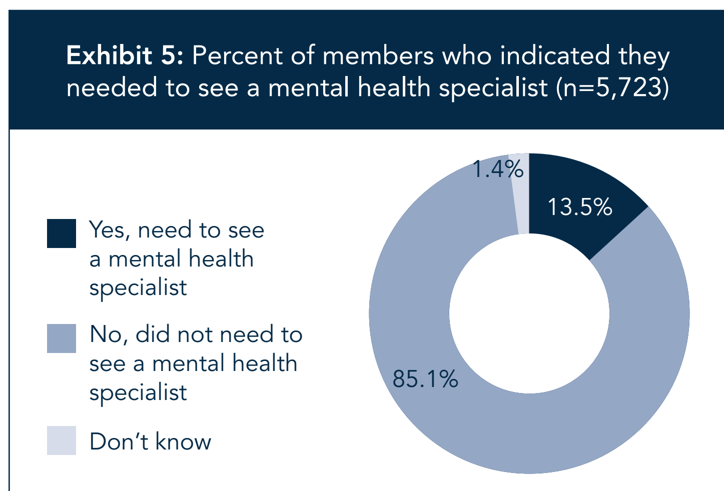
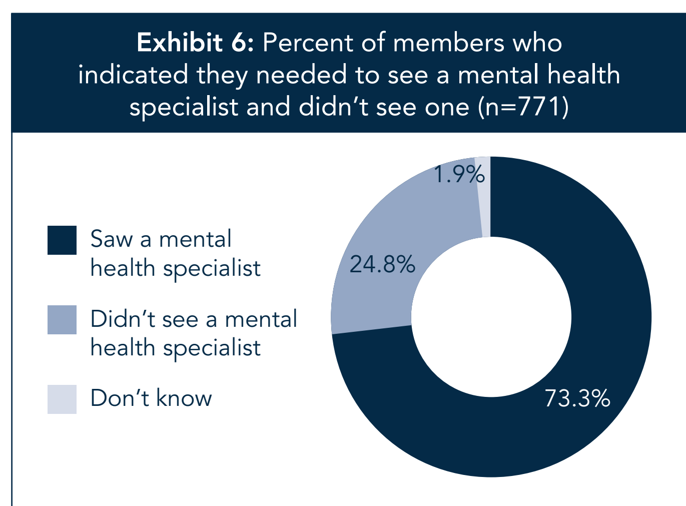
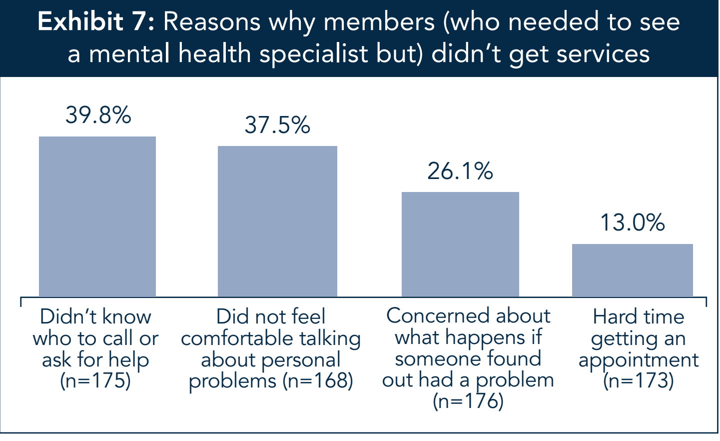



**Exhibit 6:** Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)




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)

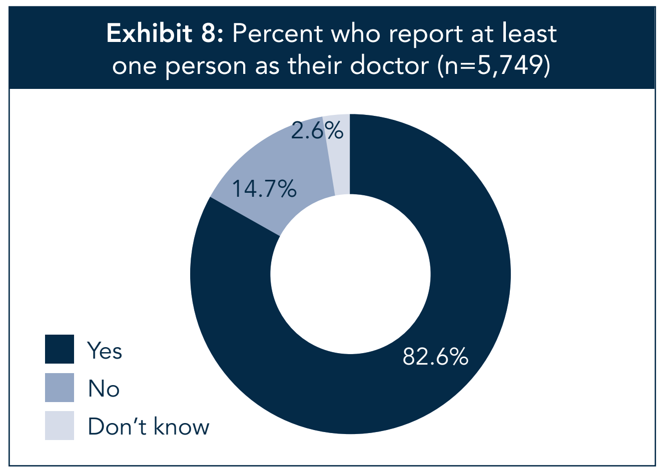
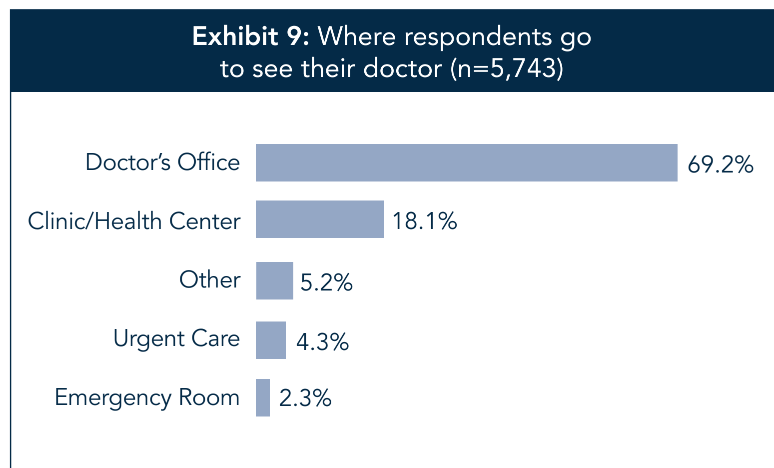



**Exhibit 9:** Where respondents go to see their doctor (n=5,743)

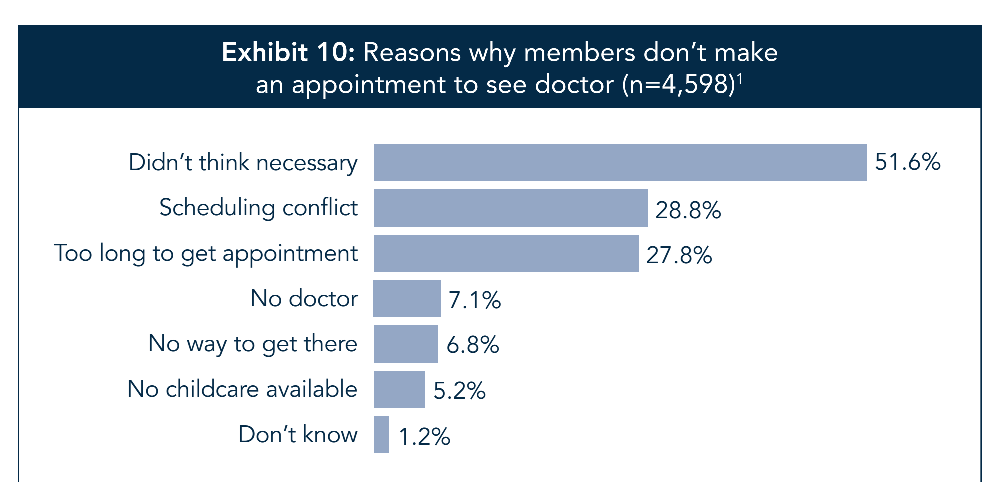



Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited 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)

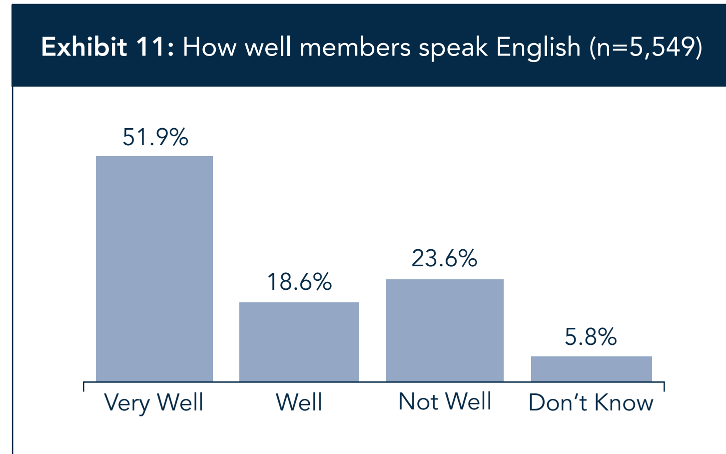
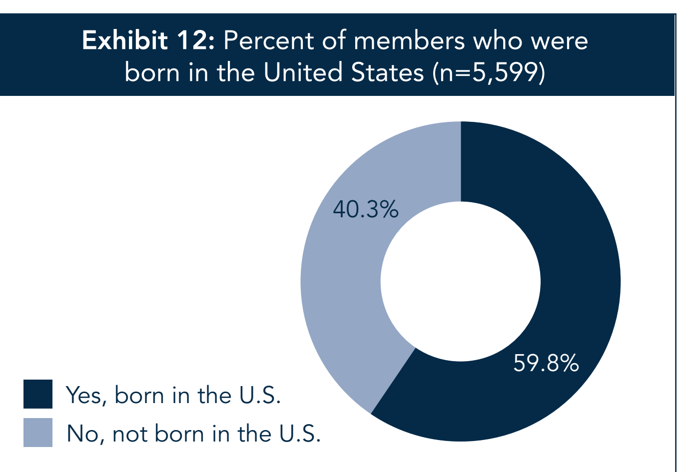



**Exhibit 12:** Percent of members who were born in the United States (n=5,599)




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.

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## 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)

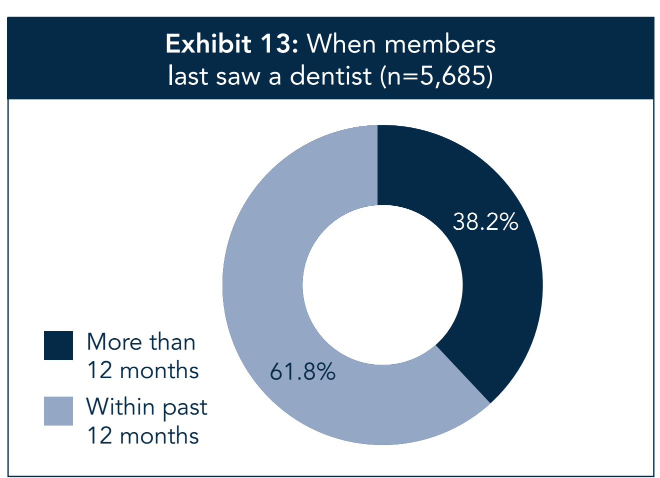
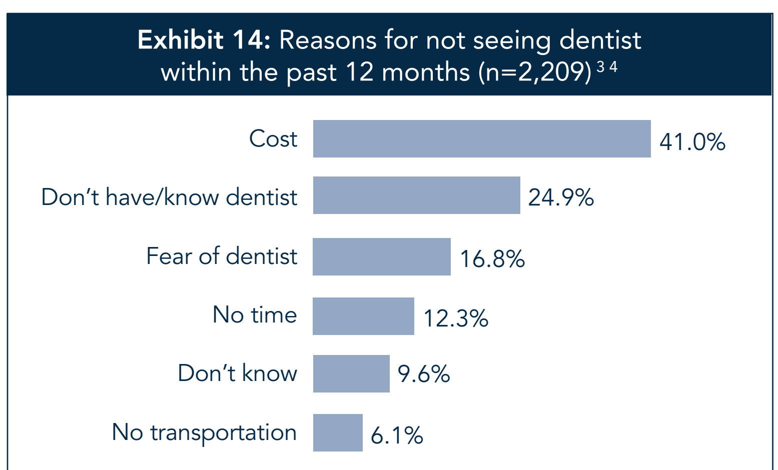



**Exhibit 14:** Reasons for not seeing dentist within the past 12 months (n=2,209) [3 4]




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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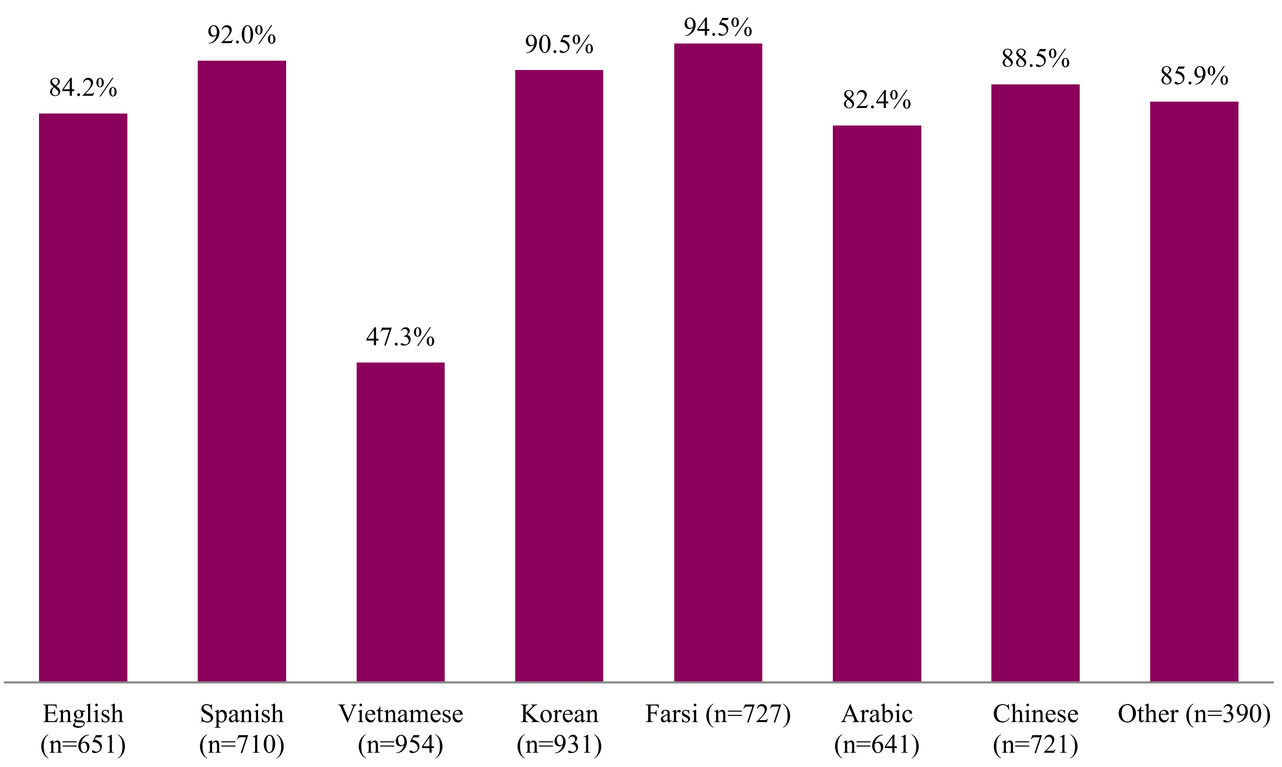
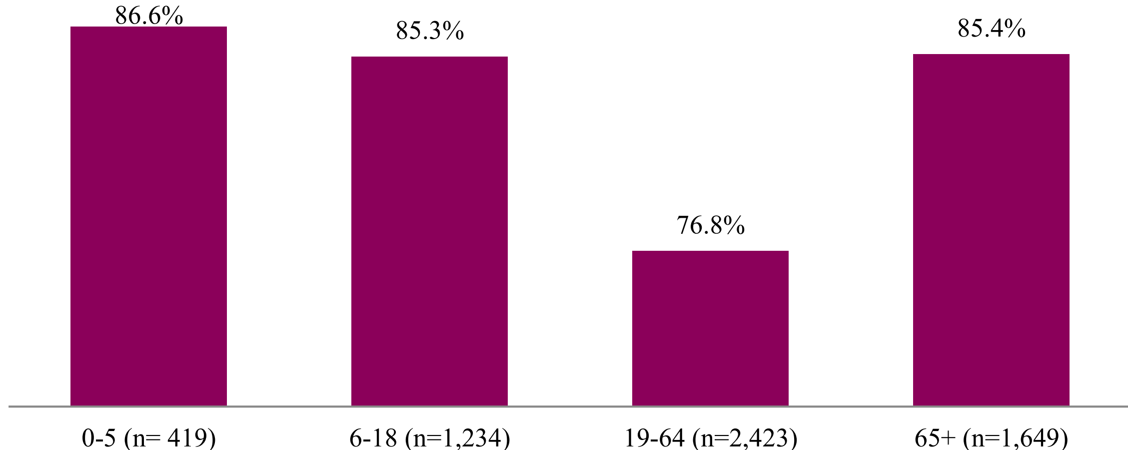
# Navigating the Healthcare System

**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:**

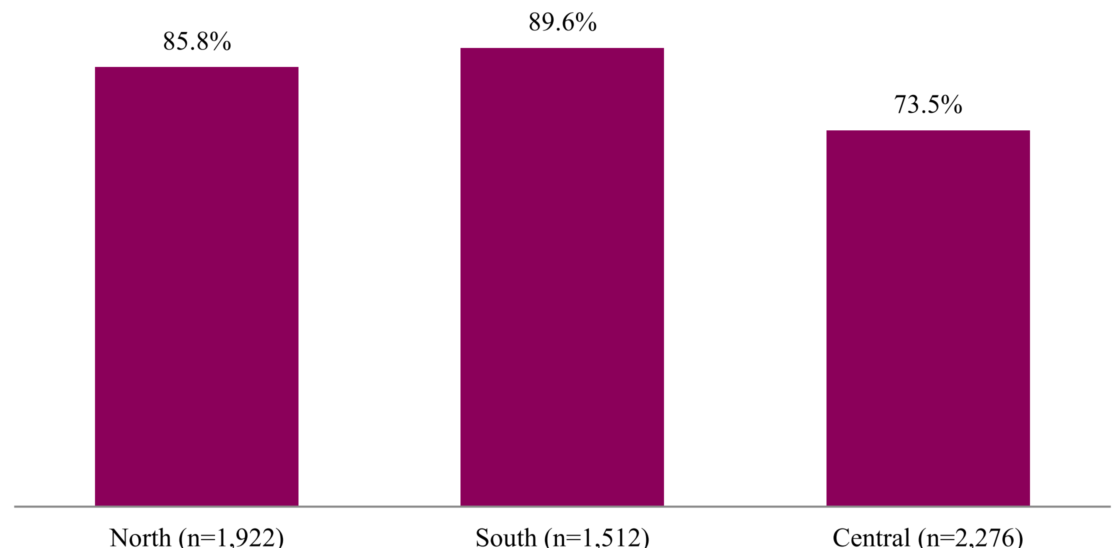


**Exhibit 2. Where respondents go to see their doctor**

**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<br>% | Check Up<br>% | Specialist Needed<br>% | Don't Know<br>% | Other<br>% | 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<br>% | Doctor helped schedule the appointment<br>% | Important for health<br>% | 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<br>% | No transportation<br>% | Appointments not at times that work with schedule<br>% | Takes too long to get an appointment<br>% | Didn't think needed to go<br>% | 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<br>% | No transportation<br>% | Appointments not at times that work with schedule<br>% | Takes too long to get an appointment<br>% | Didn't think needed to go<br>% | 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 |

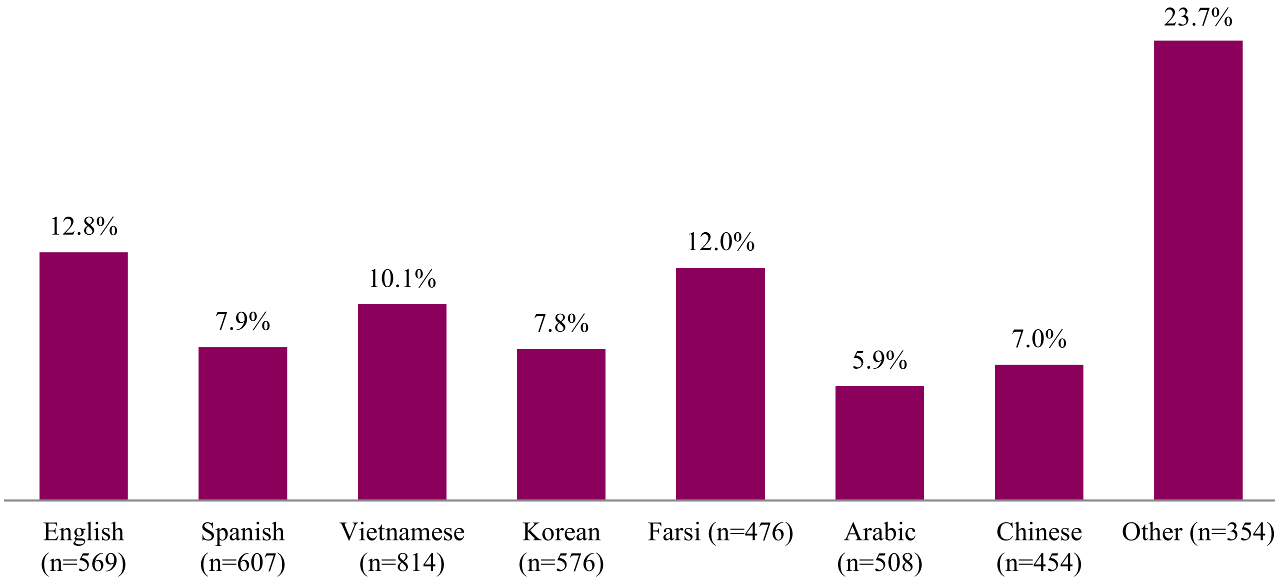
[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

**Region:**

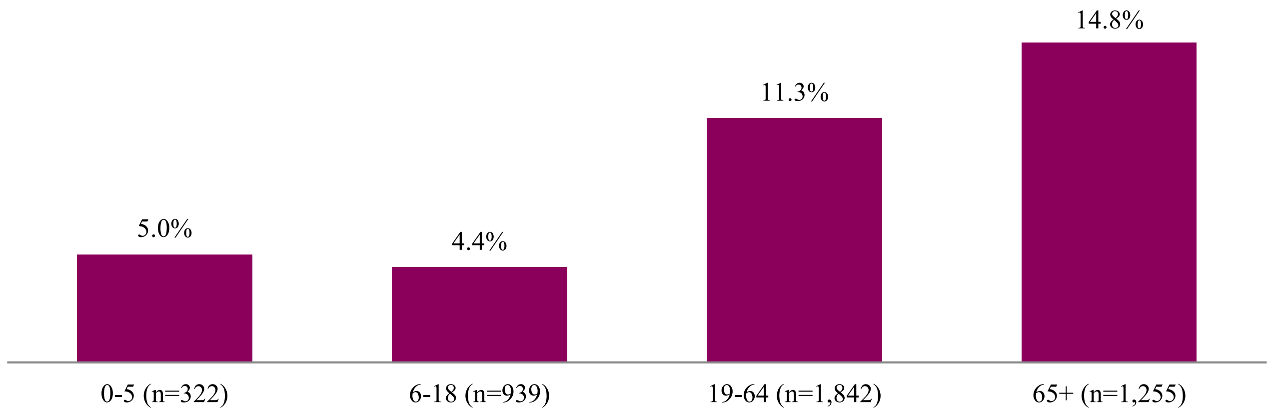
| Region | Too far away<br>% | No transportation<br>% | Appointments not at times that work with schedule<br>% | Takes too long to get an appointment<br>% | Didn't think needed to go<br>% | n |
|---|---|---|---|---|---|---|
| **North** | 14.0% | 11.3% | 24.8% | 35.9% | 31.1% | 1,567 |
| **South** | 13..6% | 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**

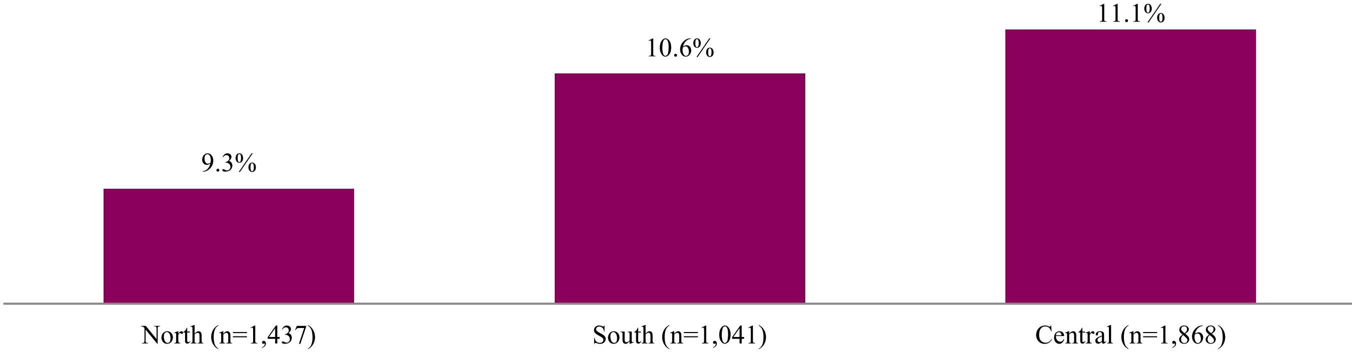
**CalOptima language:**




**Age Category:**




**Region:**



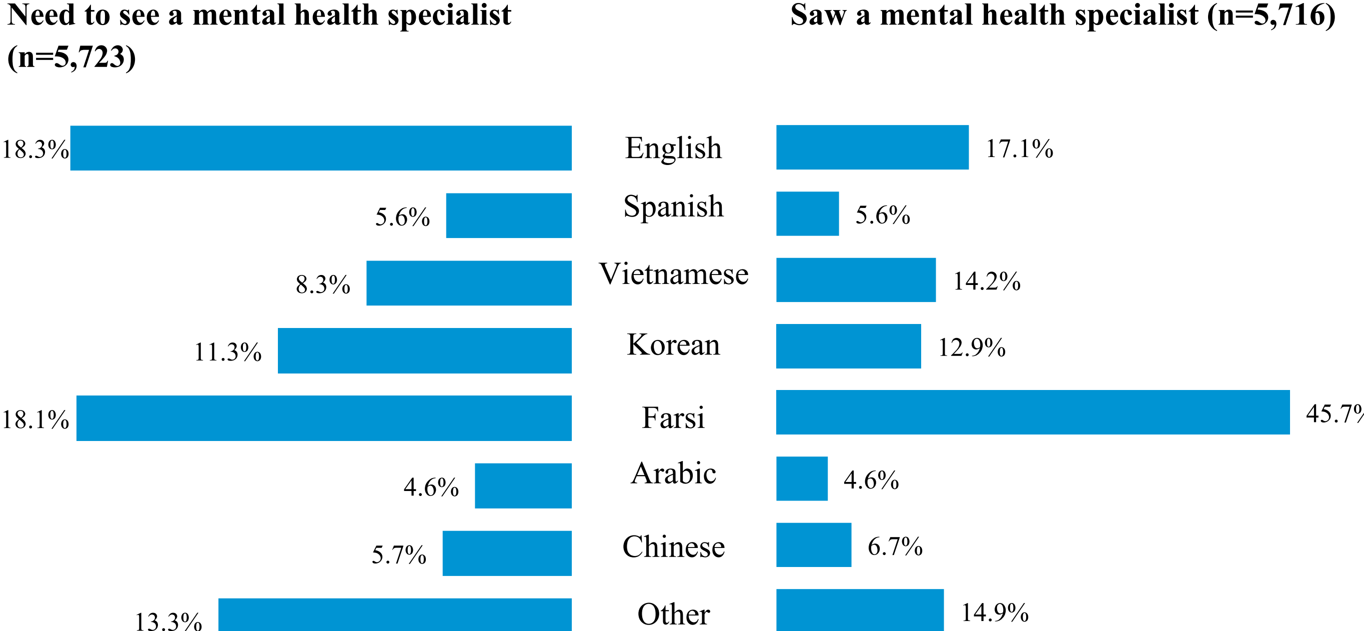
# Social and Emotional Well-Being

**Exhibit 9. Members who needed to see compared to those who saw a mental health specialist in the last 12 months[6]**

**CalOptima Language:**

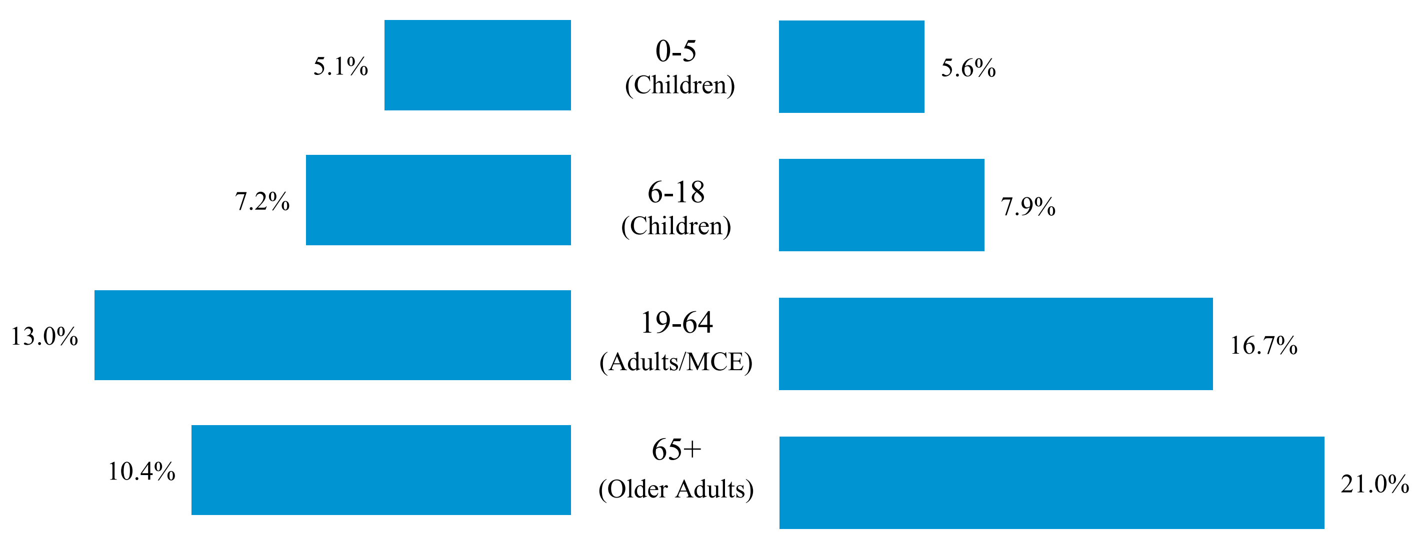
**Need to see a mental health specialist (n=5,723)**

**Saw a mental health specialist (n=5,716)**




[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:**




**Region:**

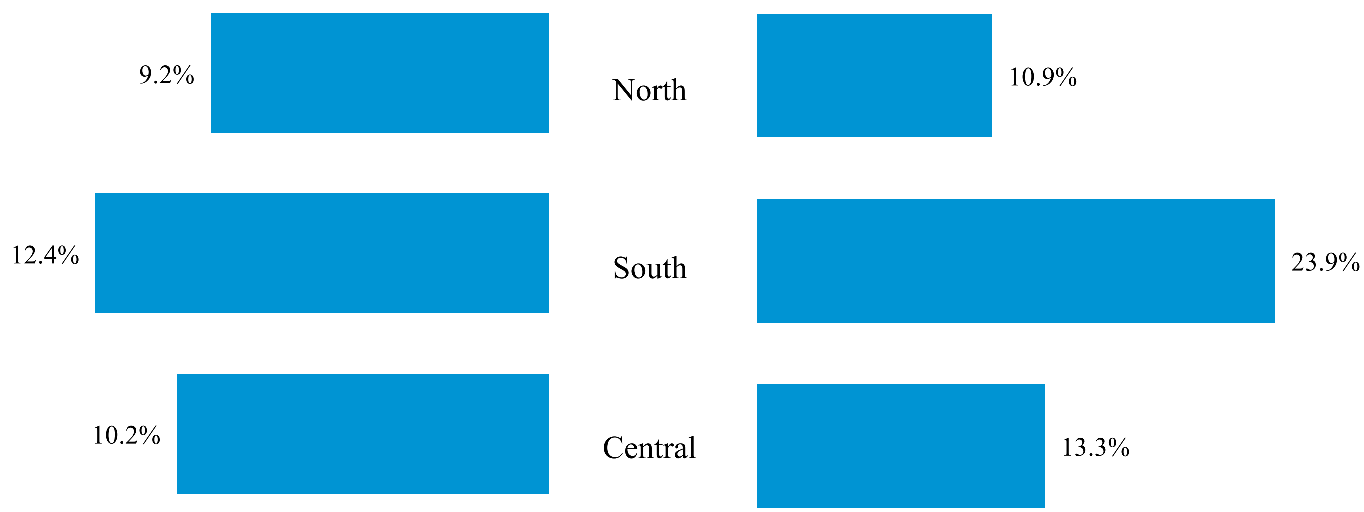
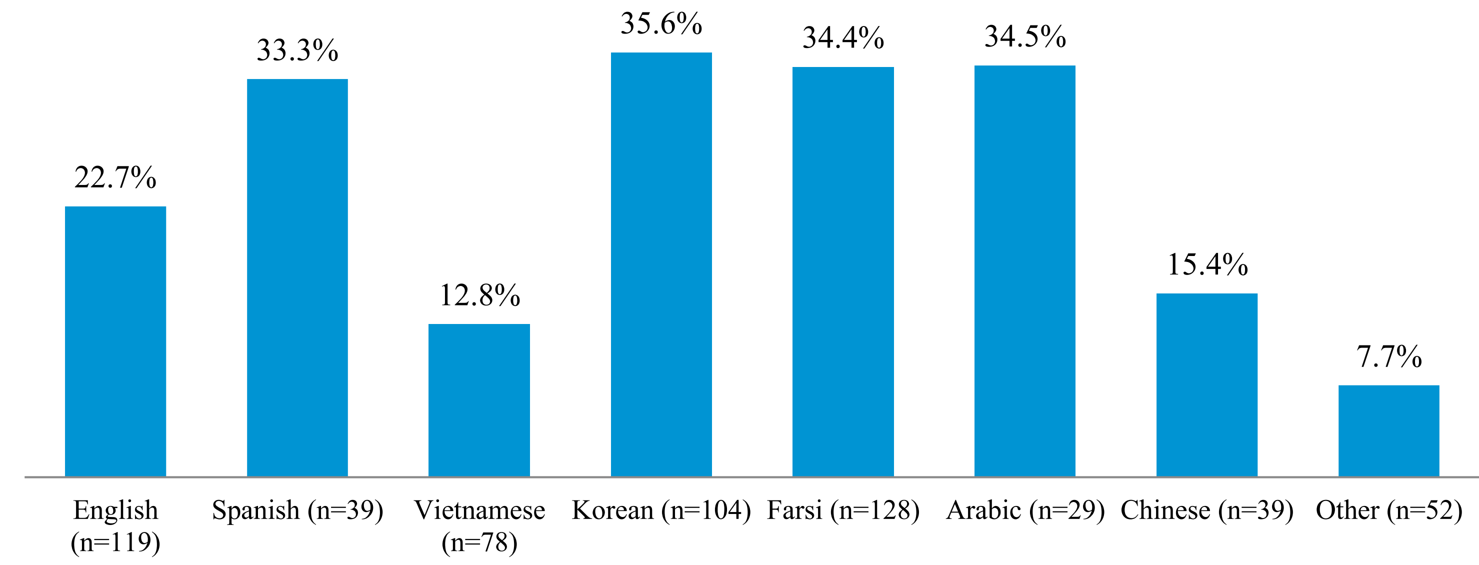
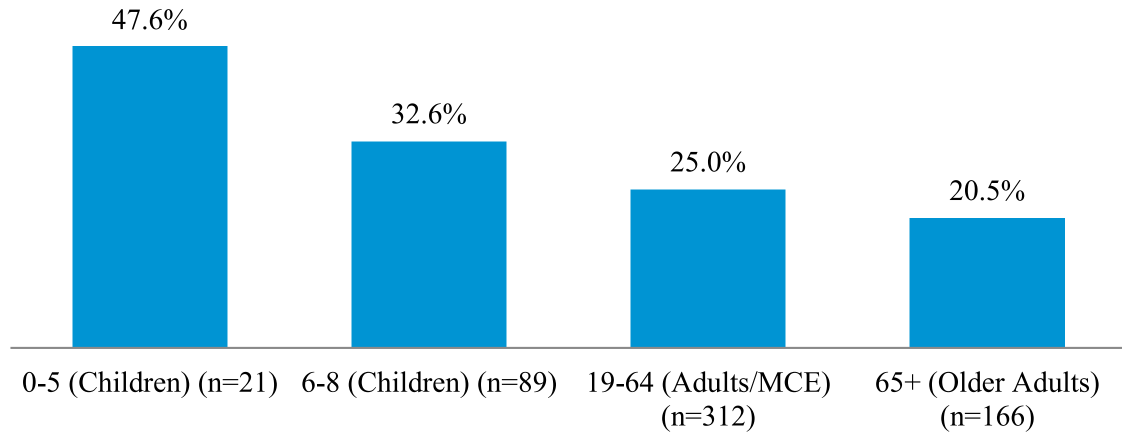


**Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist**

**CalOptima Language:**




**Age Category:**




**Region:**

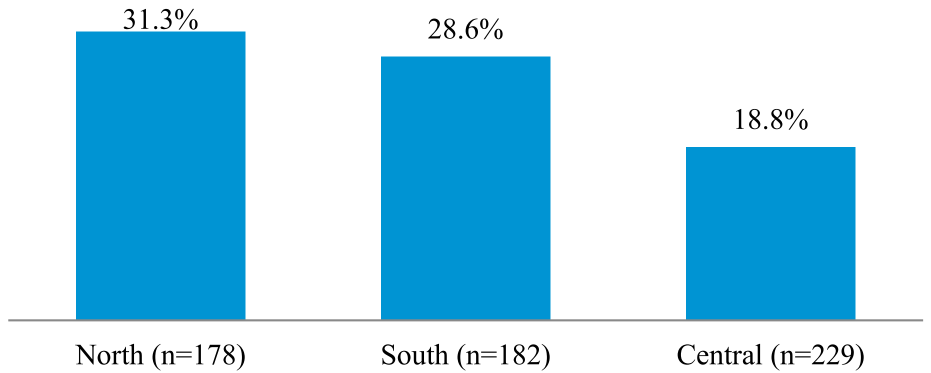
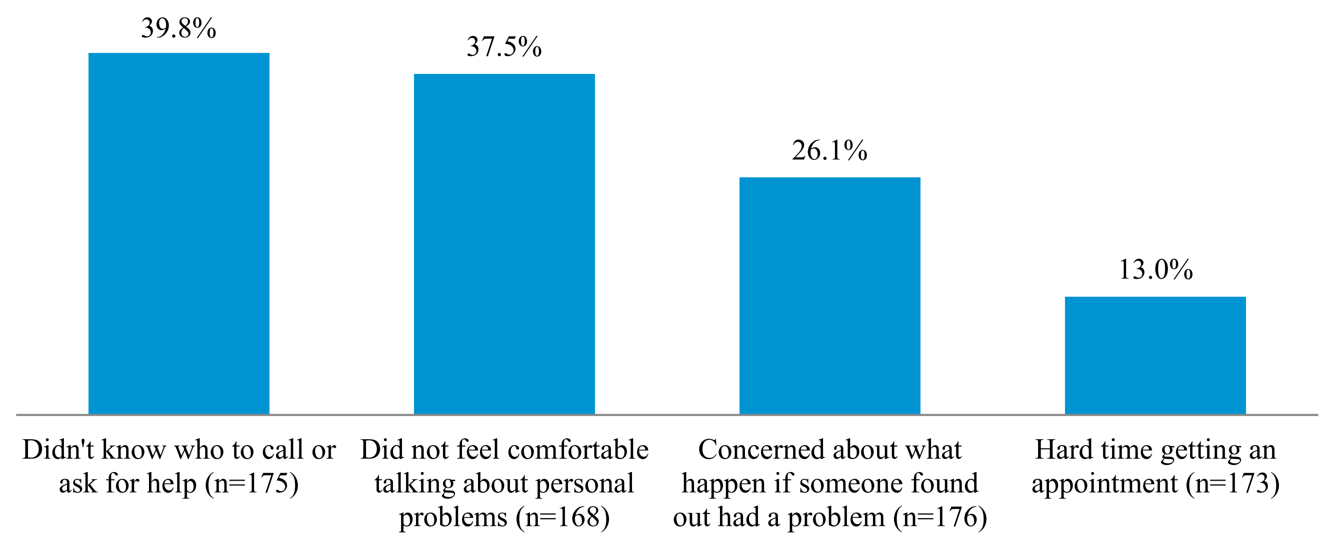


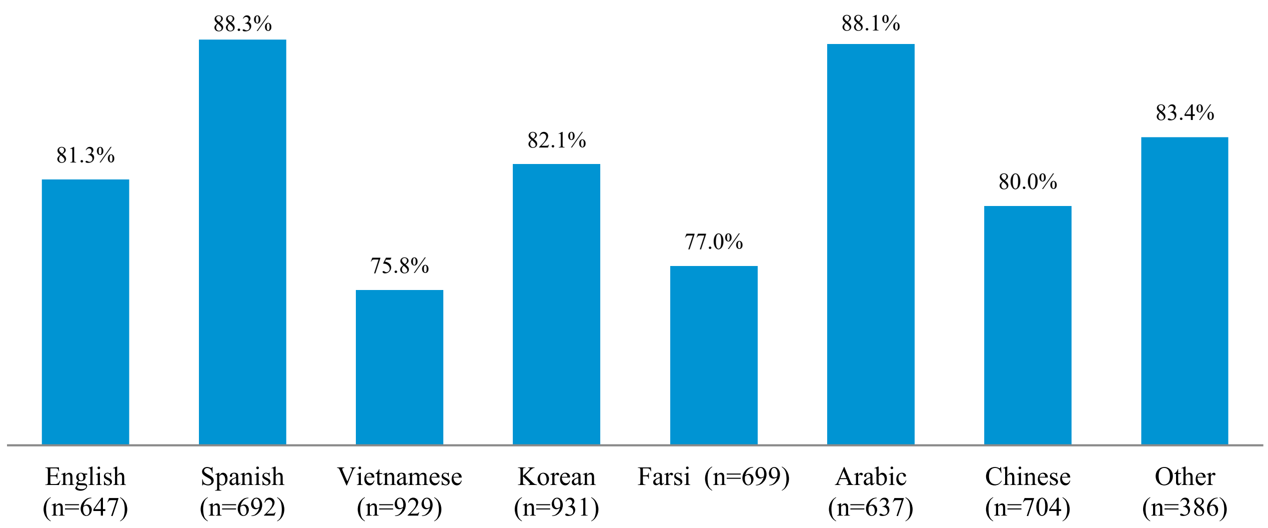
**Exhibit 11. Reasons why members didn't see mental health specialist[7]**



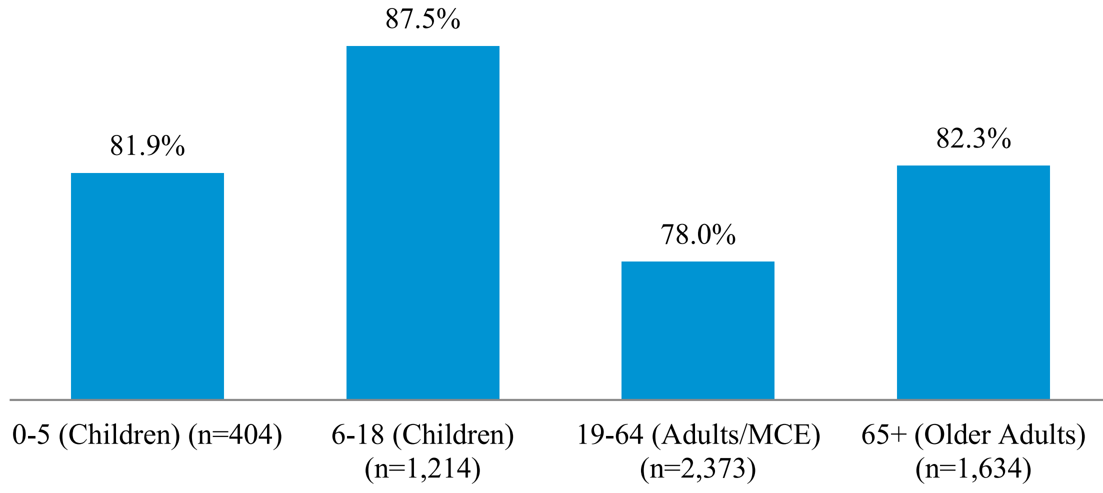

[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

**Exhibit 12. Percent of members who can share their worries with family members**

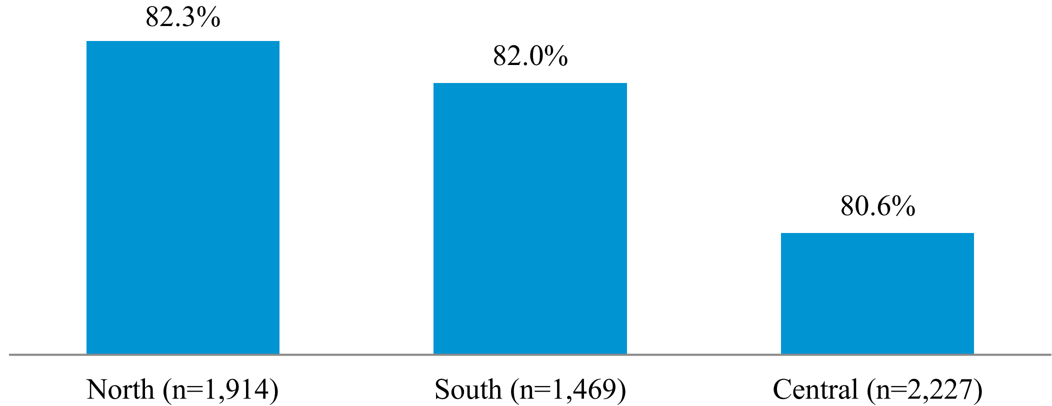
**CalOptima language:**




**Age Category:**




**Region:**

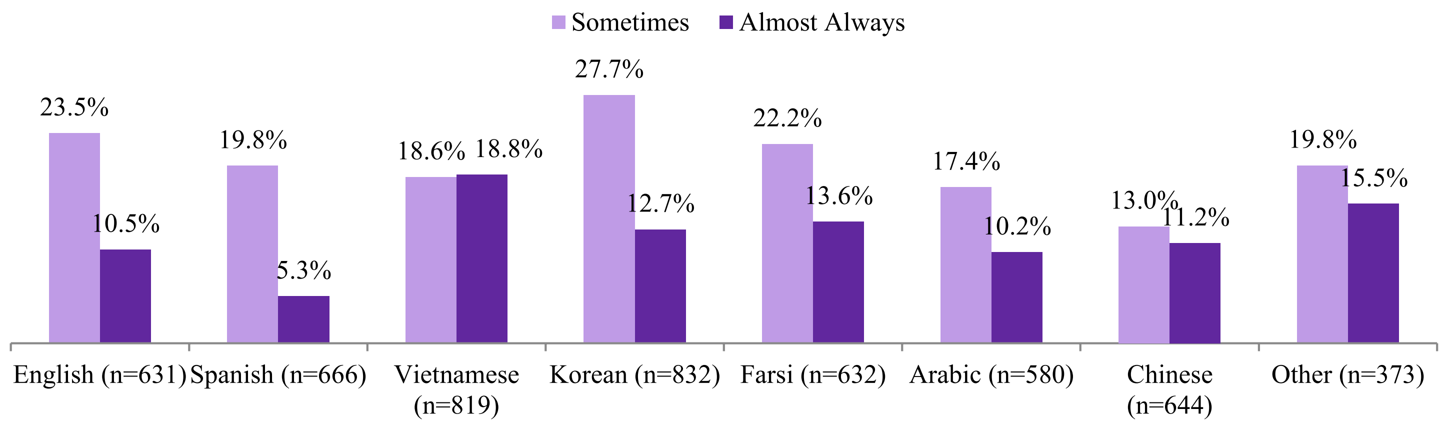


# Social Determinants of Health

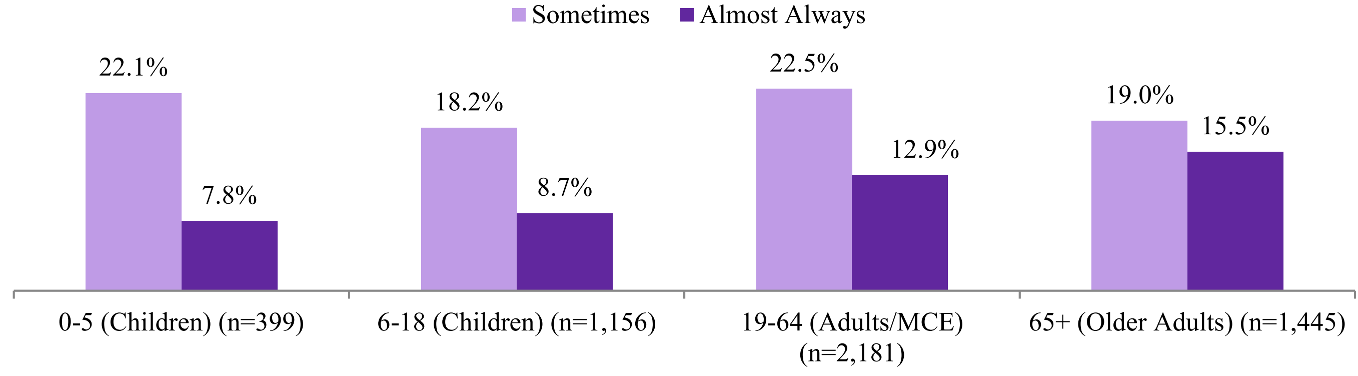
**Exhibit 13. Needed help with the following in the past 6 months:**

**Food for anyone in your household:**

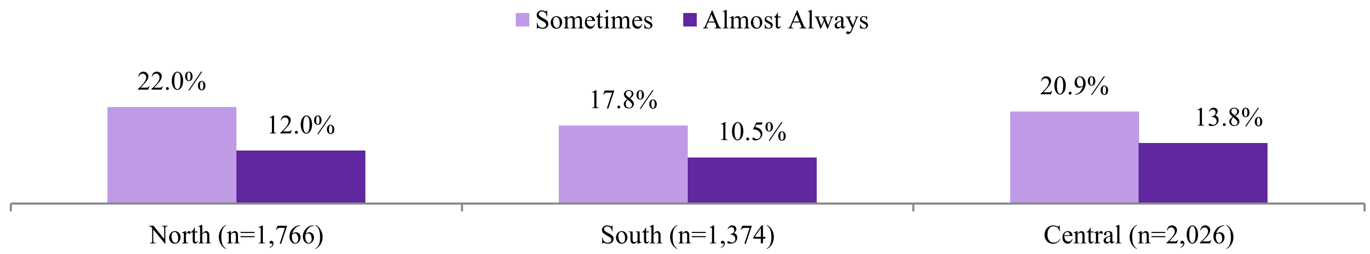
**CalOptima language:**




**Age Category:**

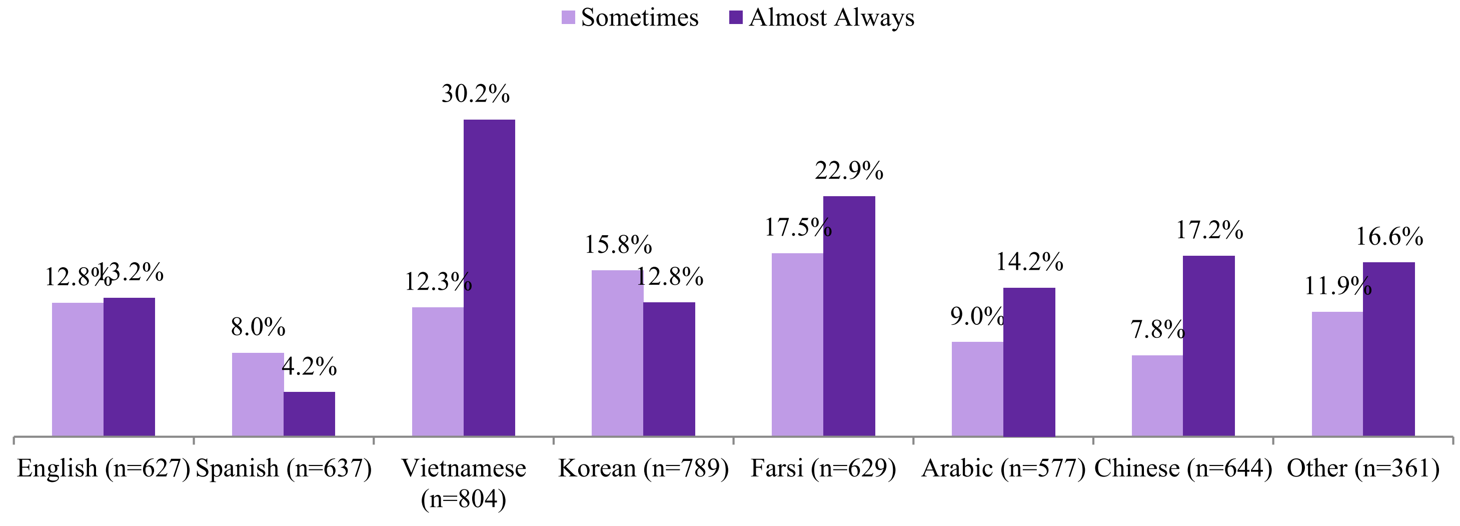



**Region:**

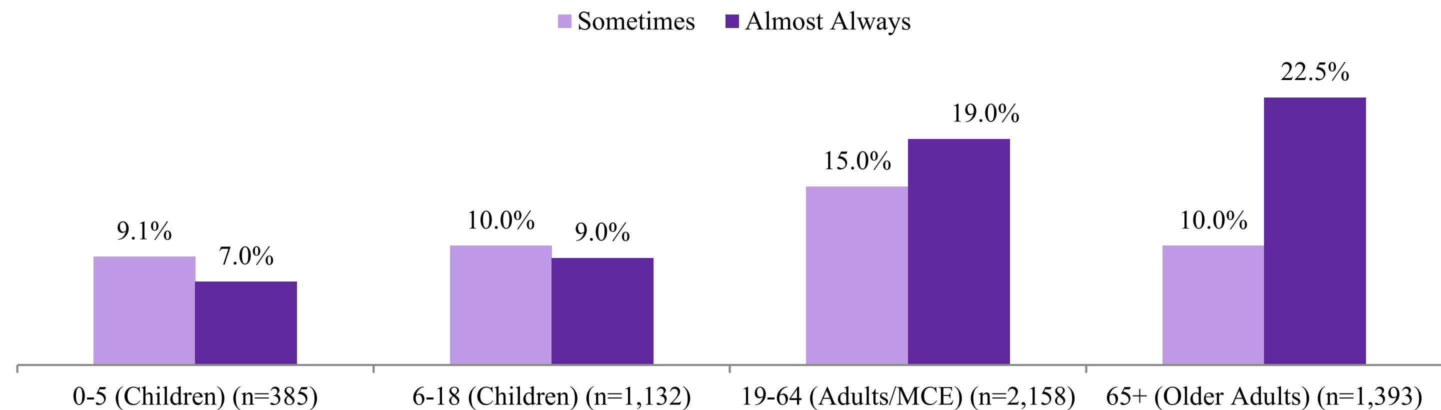


**Housing:**

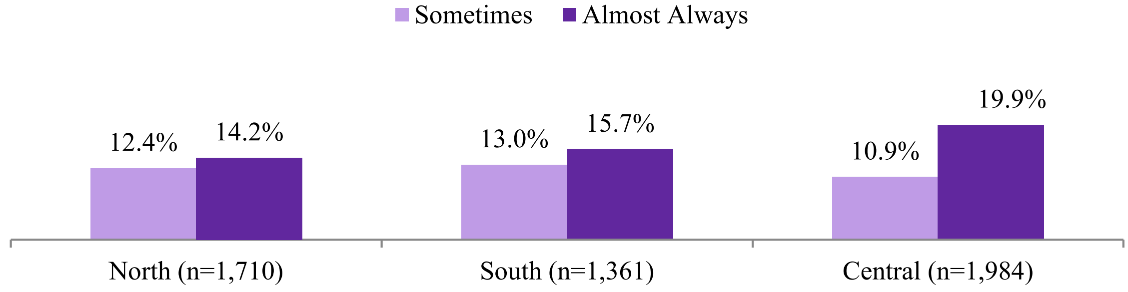
**CalOptima language:**




**Age Category:**

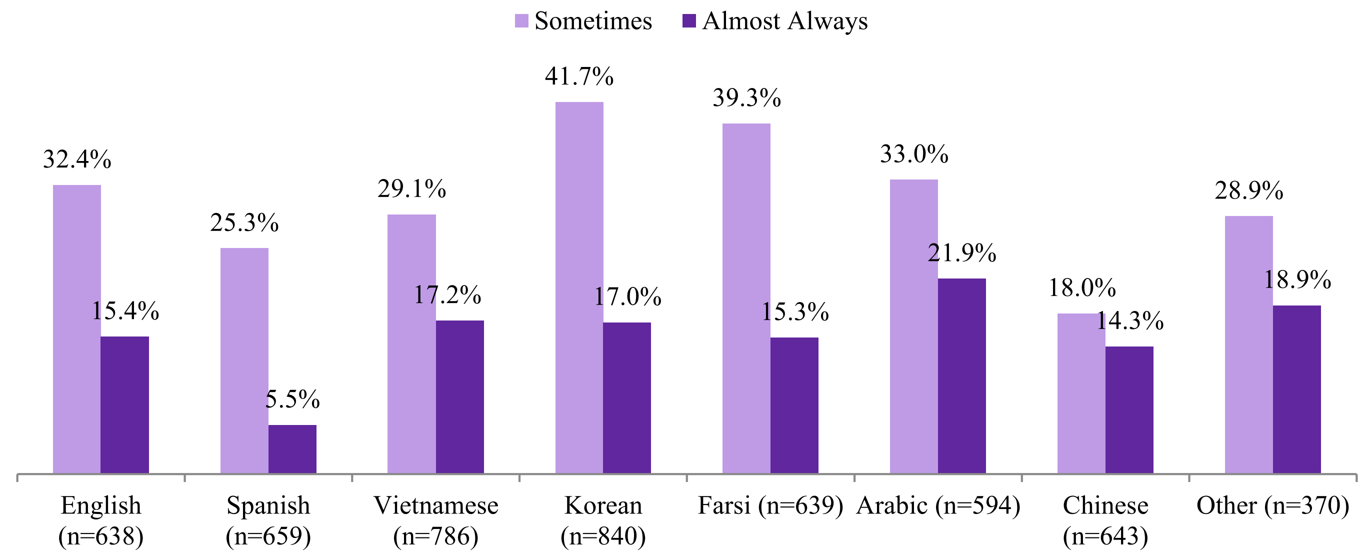



**Region:**

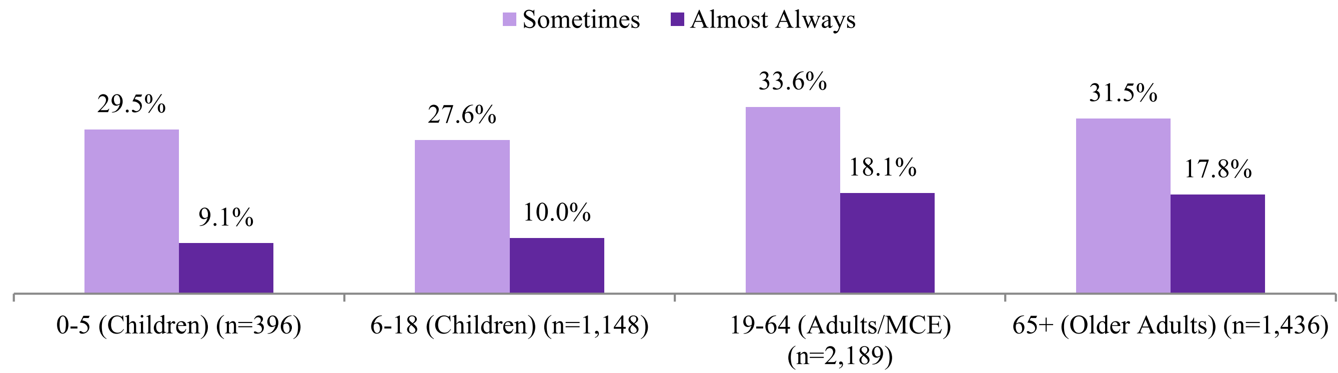


**Money to buy things need:**

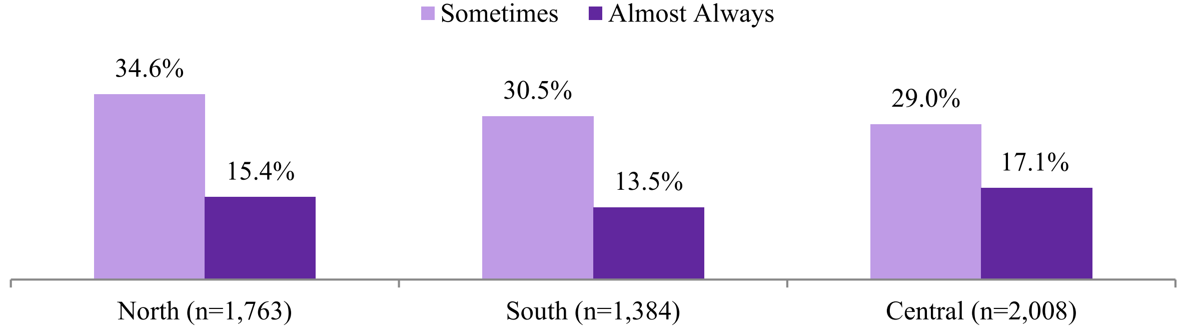
**CalOptima language:**




**Age Category:**

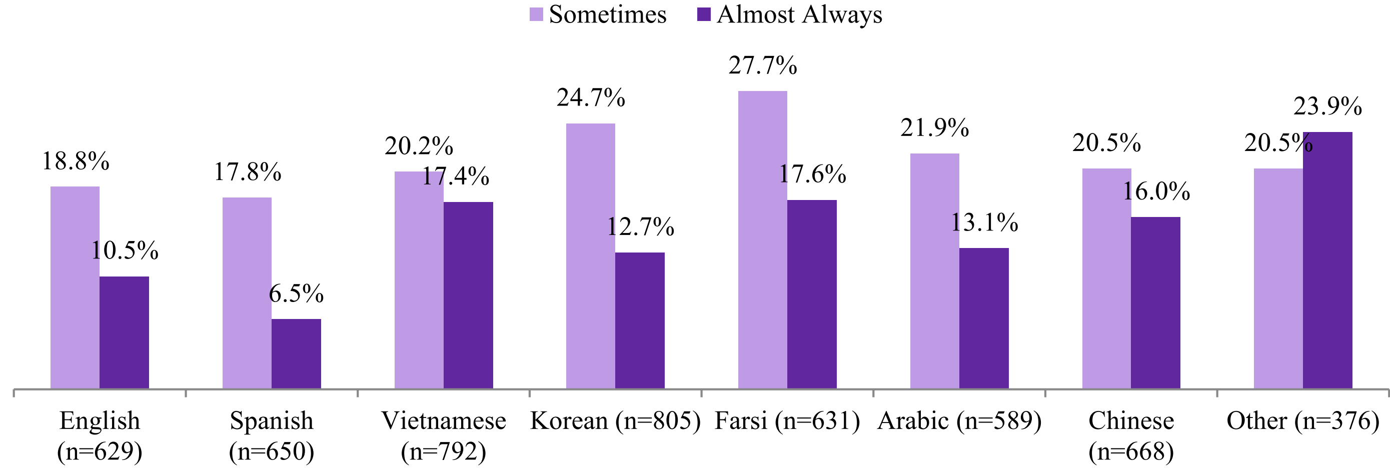



**Region:**

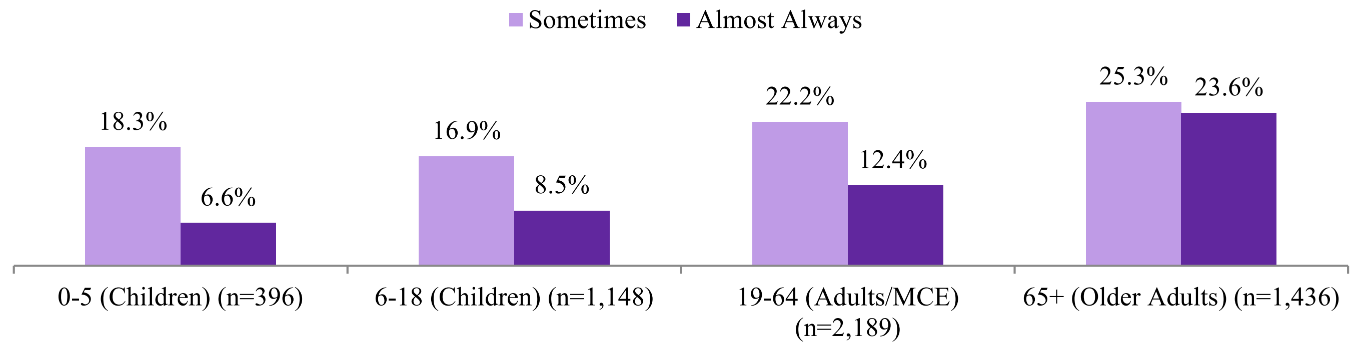


**Transportation:**

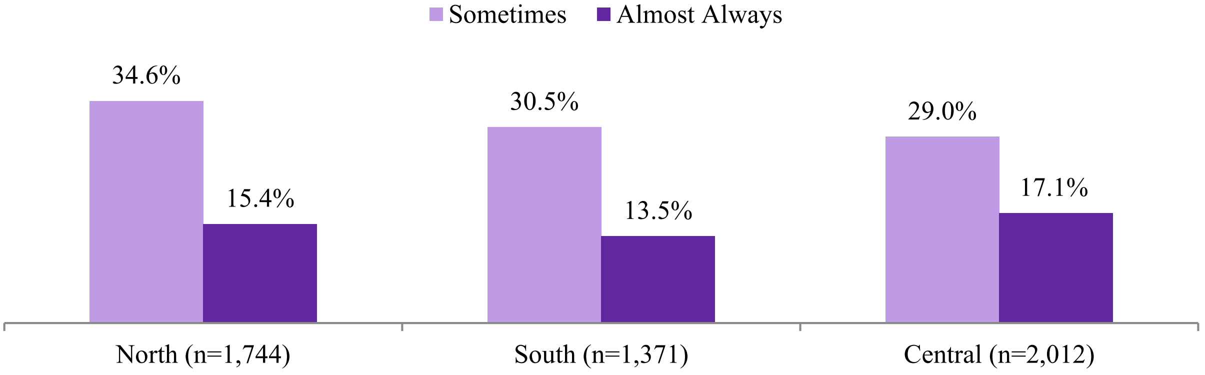
**CalOptima language:**




**Age Category:**

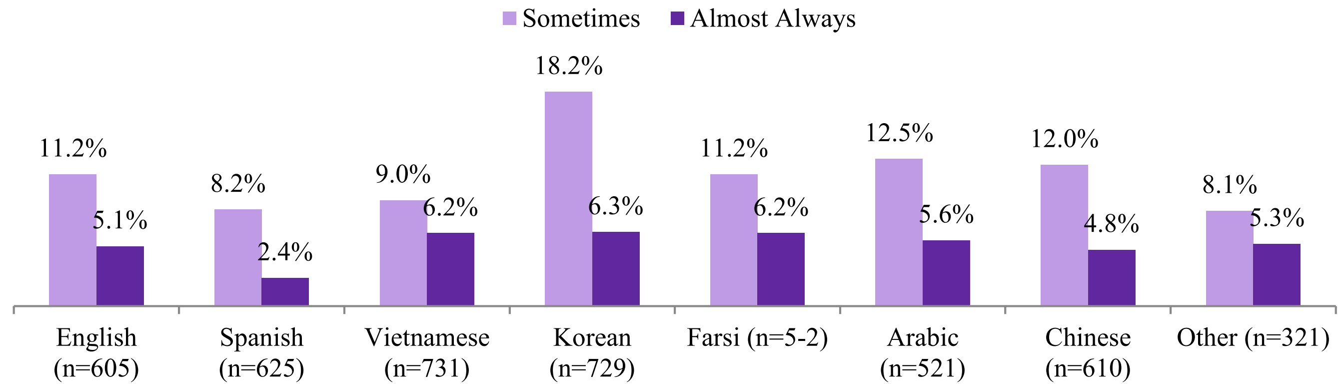



**Region:**

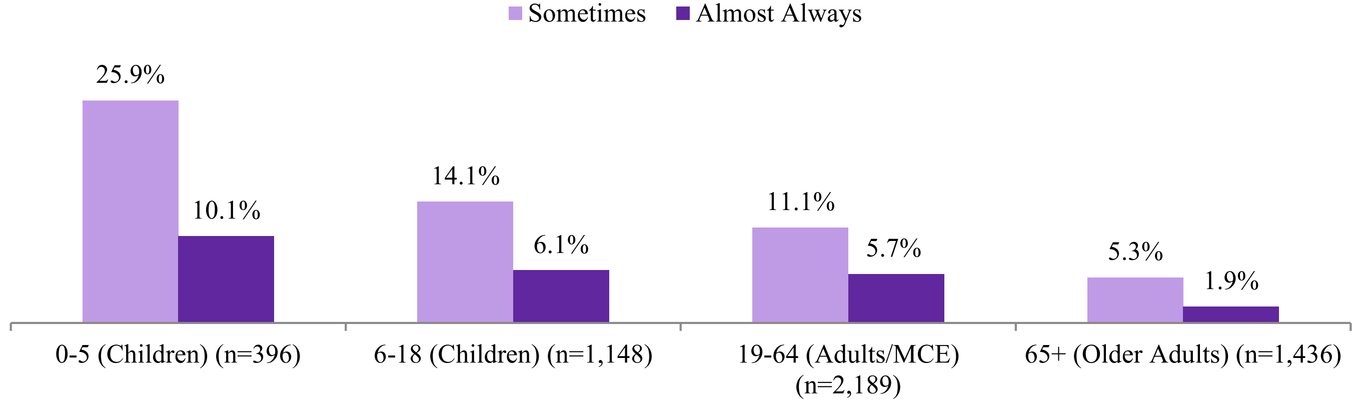


**Child care:**

**CalOptima language:**




**Age Category:**




**Region:**

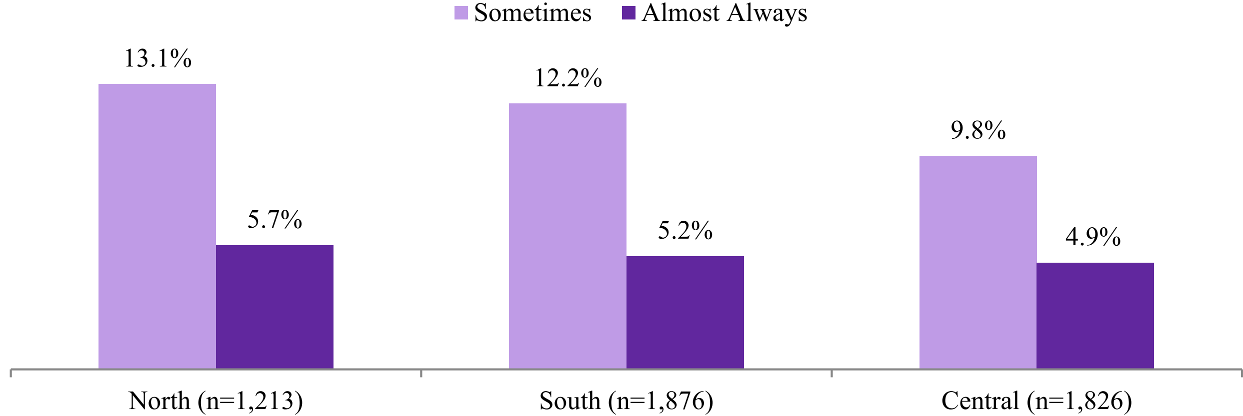
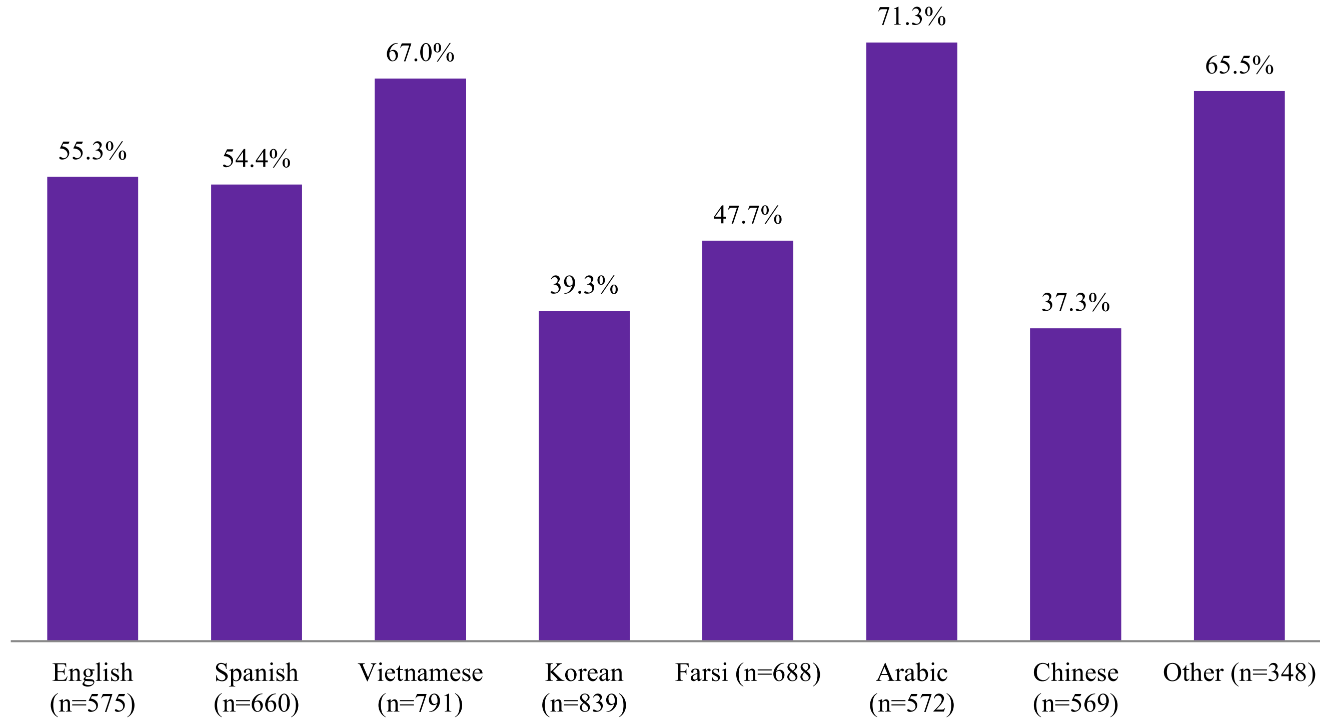


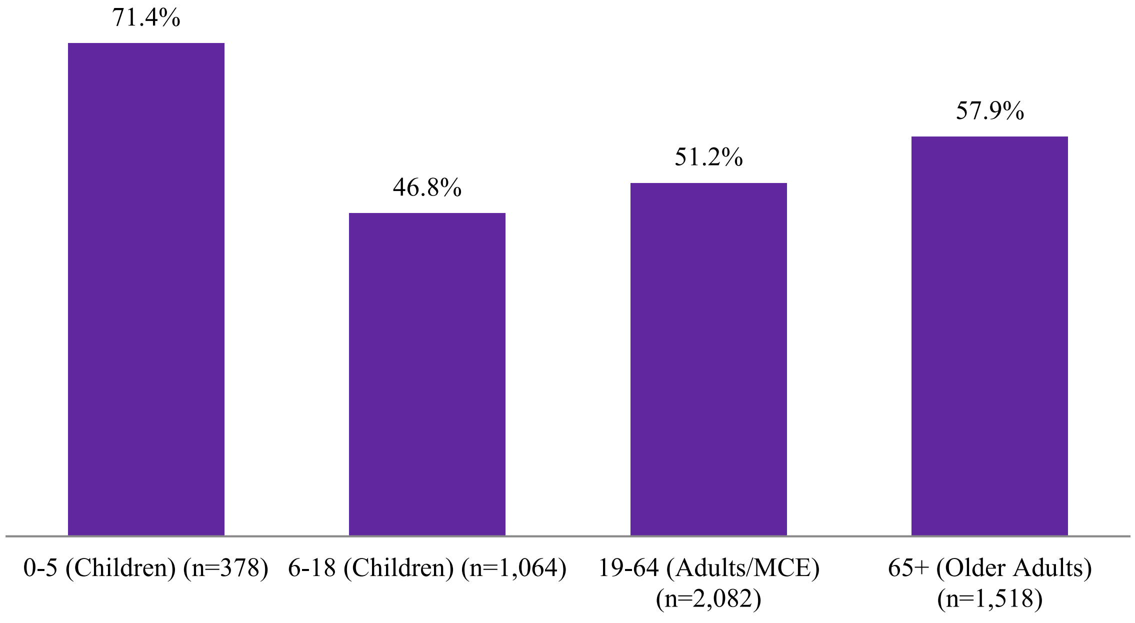
**Exhibit 14. Members who received public benefits**

**Percent of members who receive public benefits:**

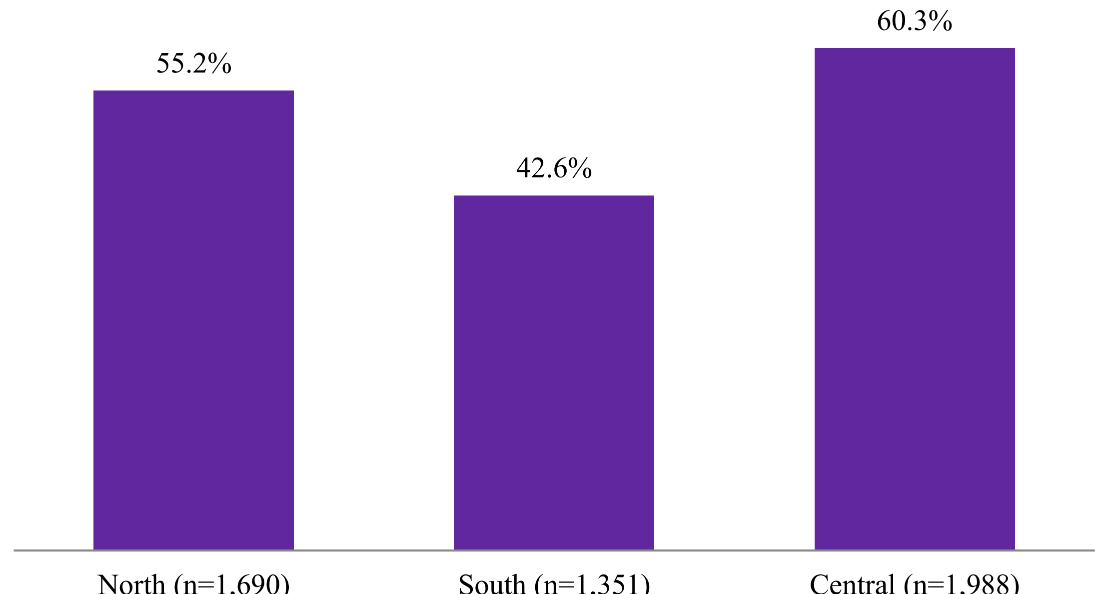
**CalOptima language:**




**Age Category:**



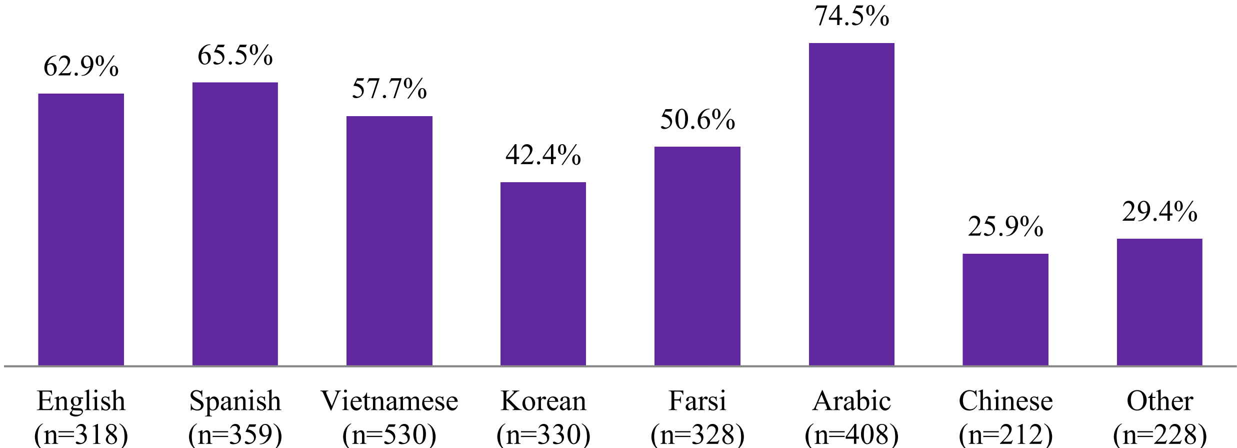
**Region:**



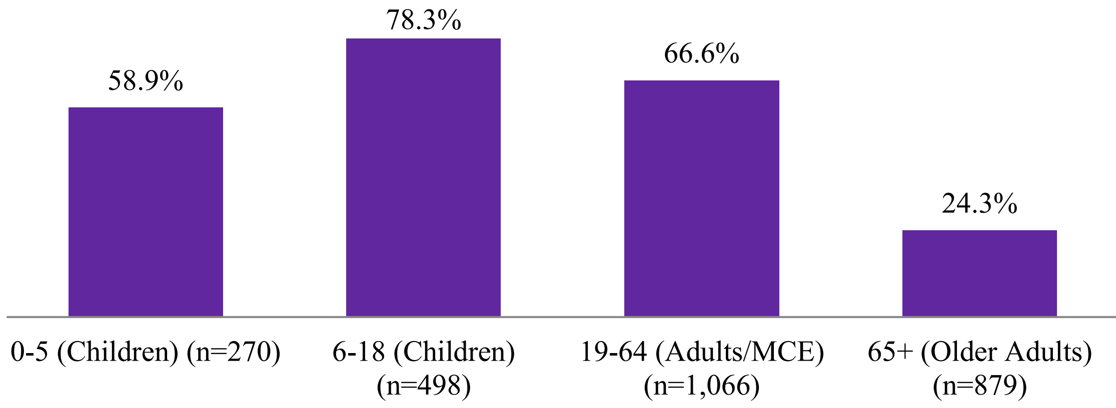
**Type of public benefits that members receive[8]:**

**Receive CalFresh as a public benefit:**

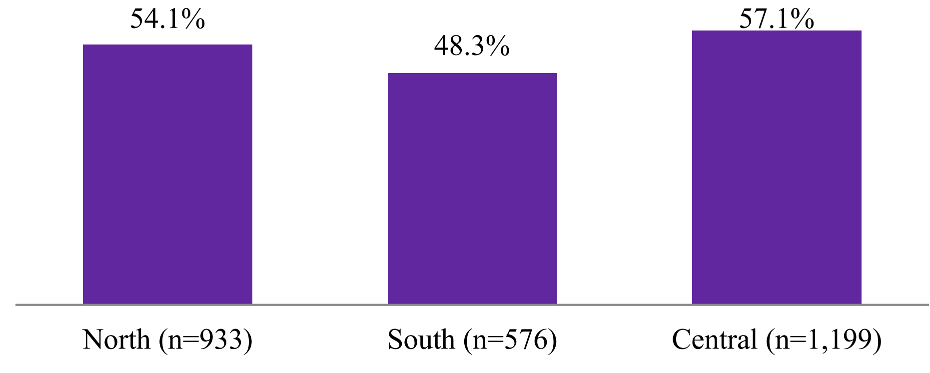
**CalOptima language:**




**Age Category:**



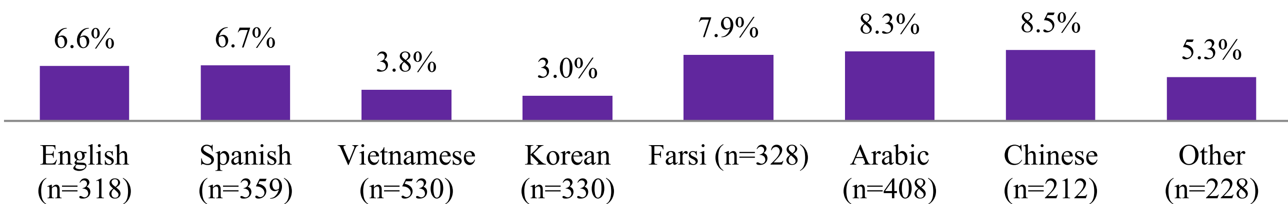

**Region:**



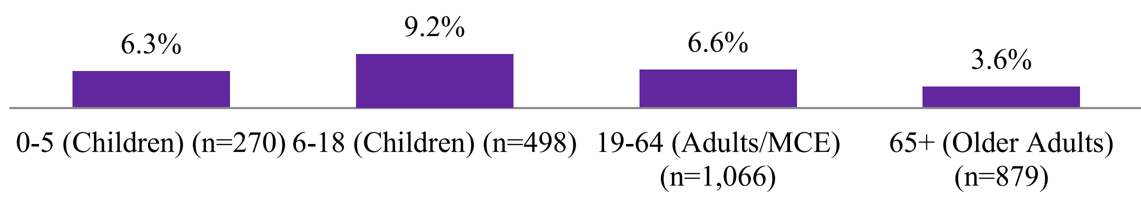

[8] Only reporting those who reported that they received at least one public benefit.

**Receive TANF or CalWorks as a public benefit:**

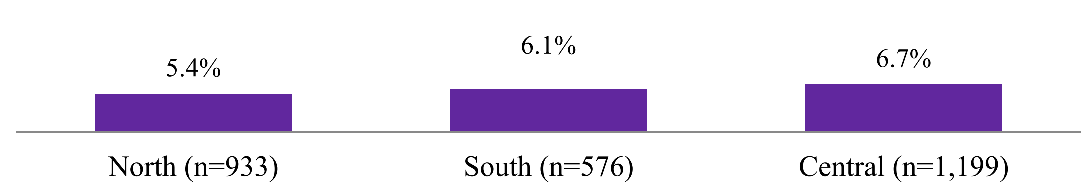
**CalOptima language:**




**Age Category:**

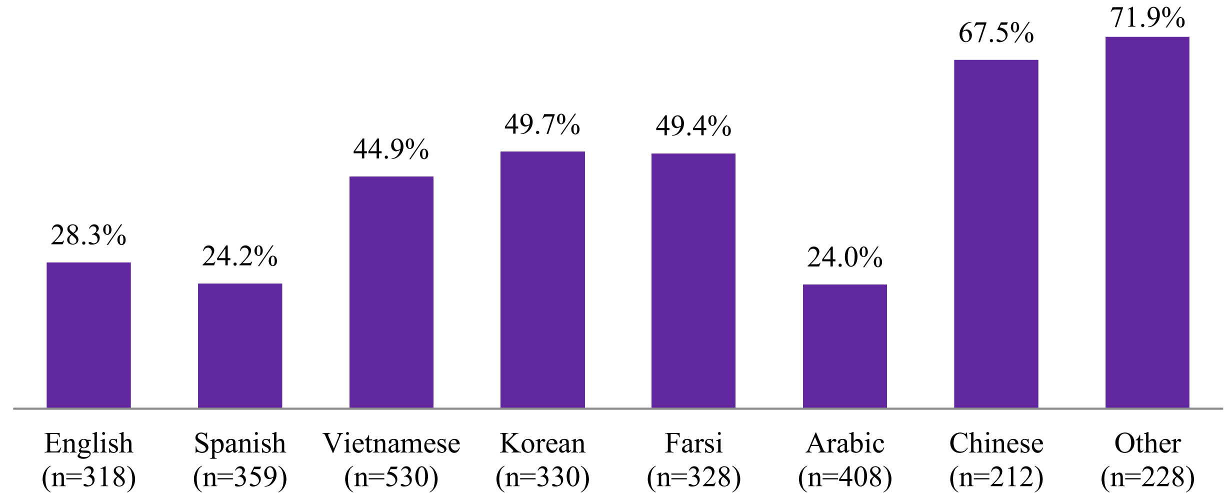



**Region:**

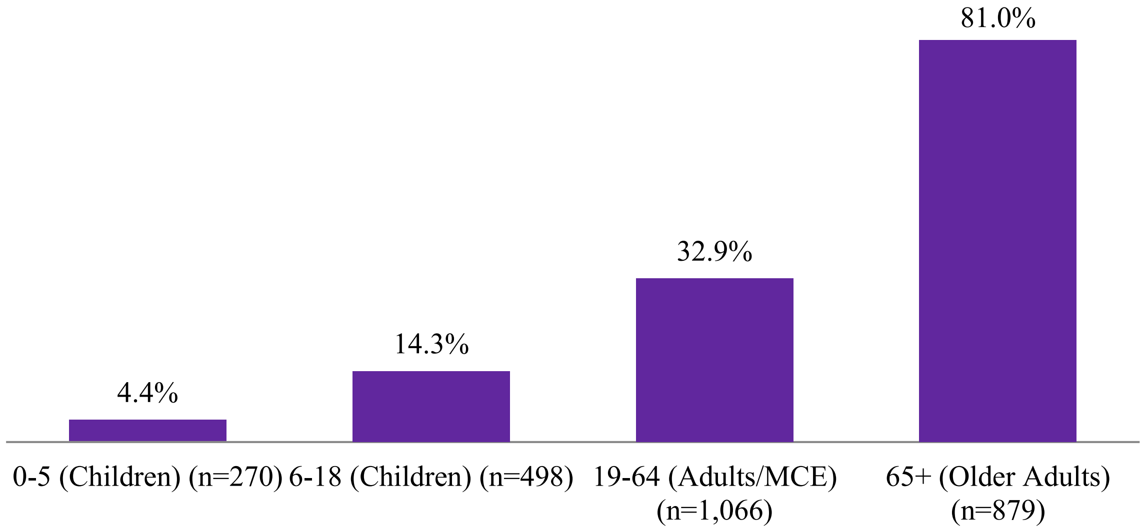


**Receive SSI or SSDI as a public benefit:**

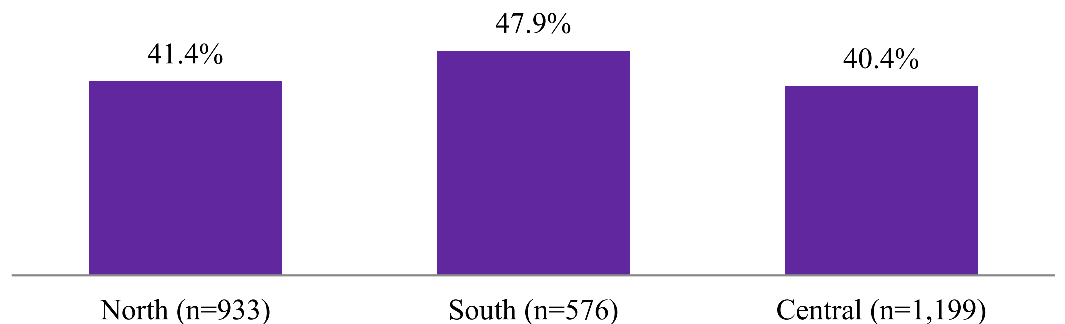
**CalOptima language:**




**Age Category:**

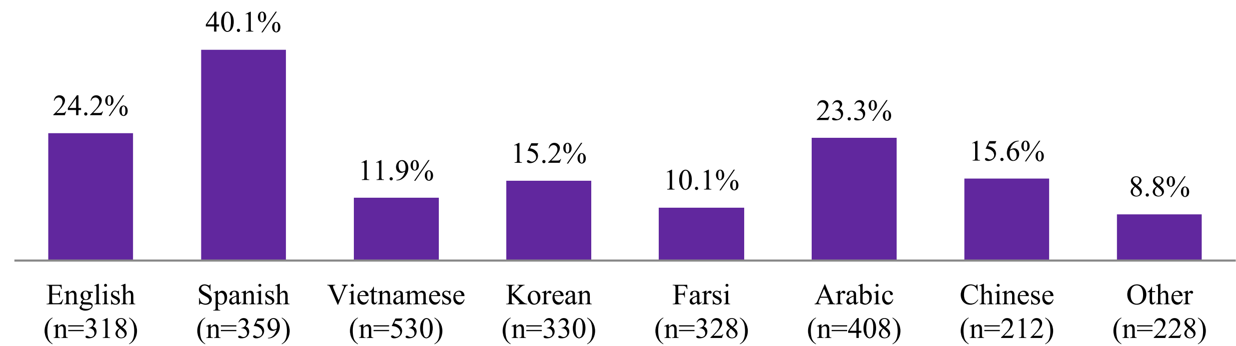



**Region:**

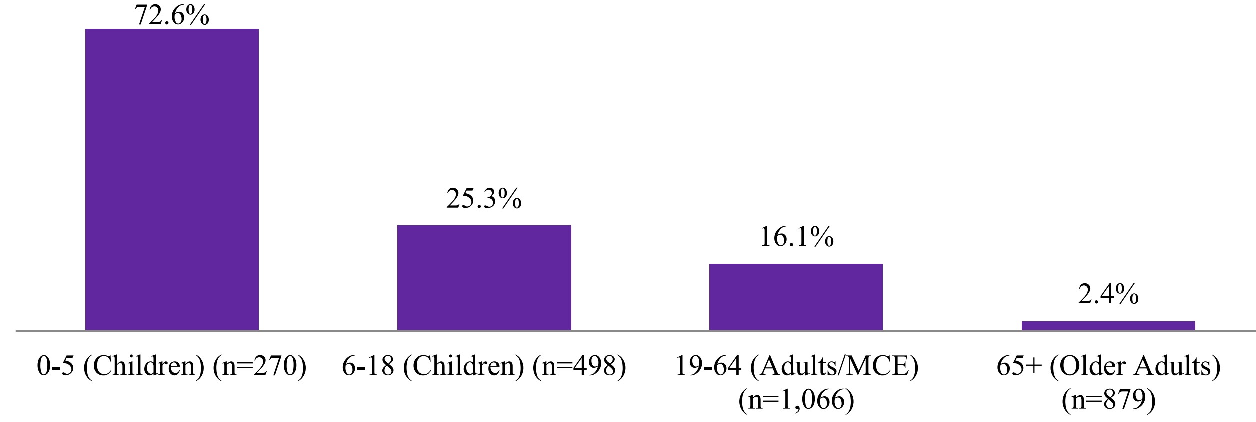


**Receive WIC as a public benefit:**

**CalOptima language:**




**Age Category:**




**Region:**

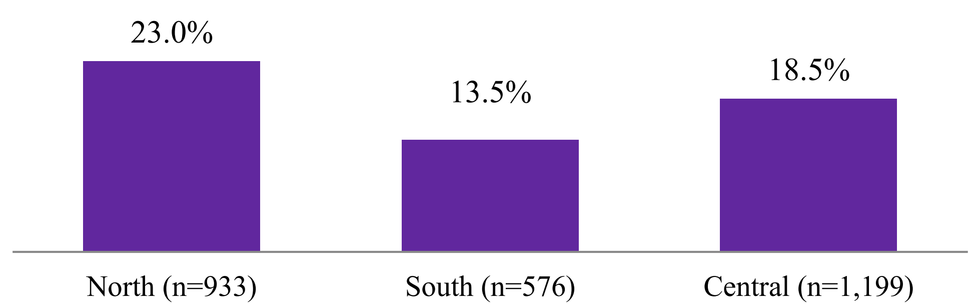


**Exhibit 15. Personal activities participation:**

**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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>%** | **Once a month<br>%** | **Once in the last 6 months<br>%** | **Never<br>%** | **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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>%** | **Once a month<br>%** | **Once in the last 6 months<br>%** | **Never<br>%** | **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<br>%** | **Once a month<br>%** | **Once in the last 6 months<br>%** | **Never<br>%** | **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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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 |

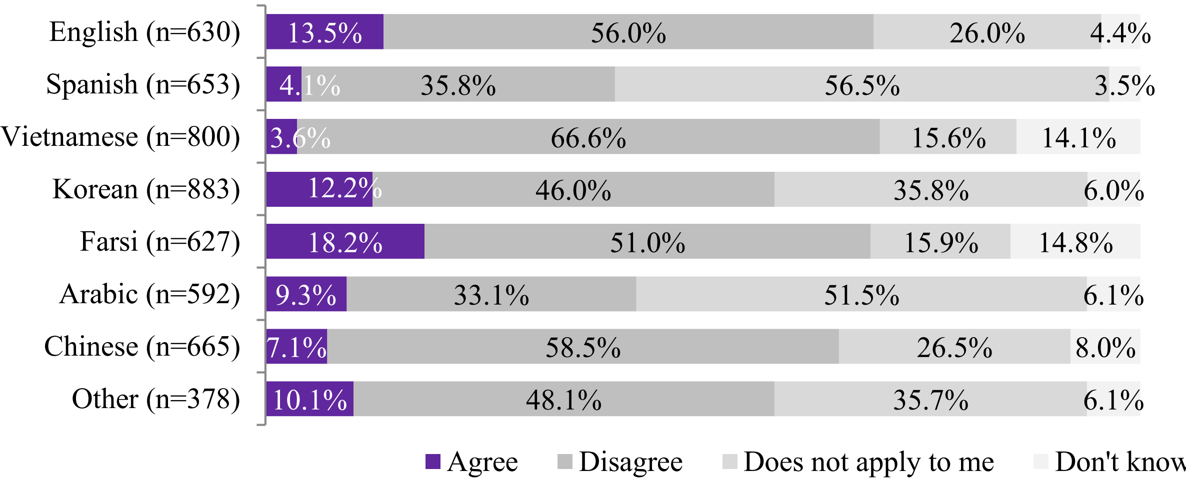
| Have enough time for self | Once a week % | Once a month % | Once in the last 6 months % | Never % | n |
|---|---|---|---|---|---|
| **North** | 76.2% | 10.9% | 3.8% | 9.1% | 1,694 |
| **South** | 81.0% | 9.2% | 3.3% | 6.5% | 1,263 |
| **Central** | 78.5% | 9.2% | 2.3% | 9.9% | 1,880 |

| 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 |

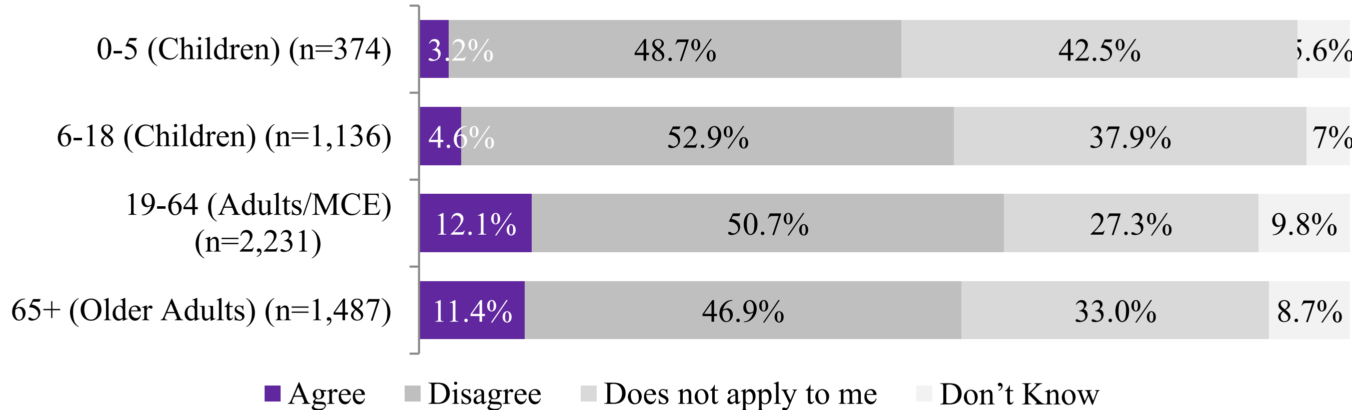
**Exhibit 16. Feelings towards community and home enviroment:**

**Feeling lonely and isolated:**

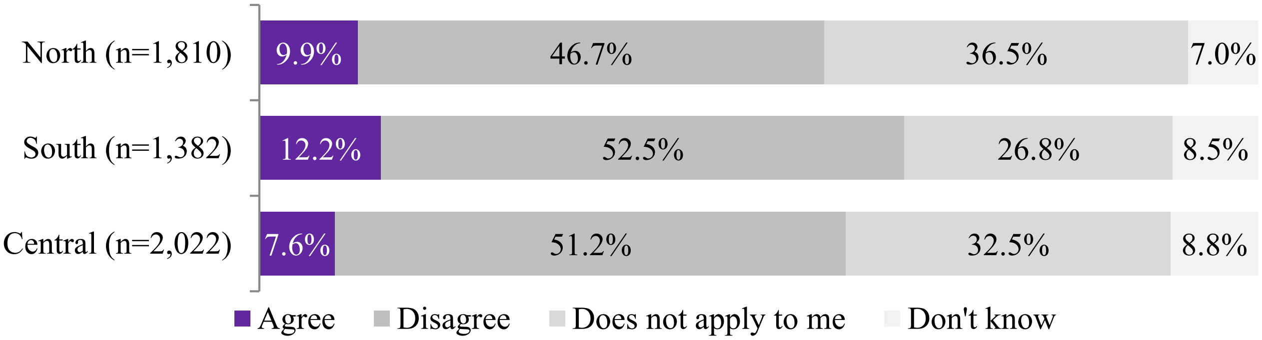
**CalOptima language:**




**Age Category:**

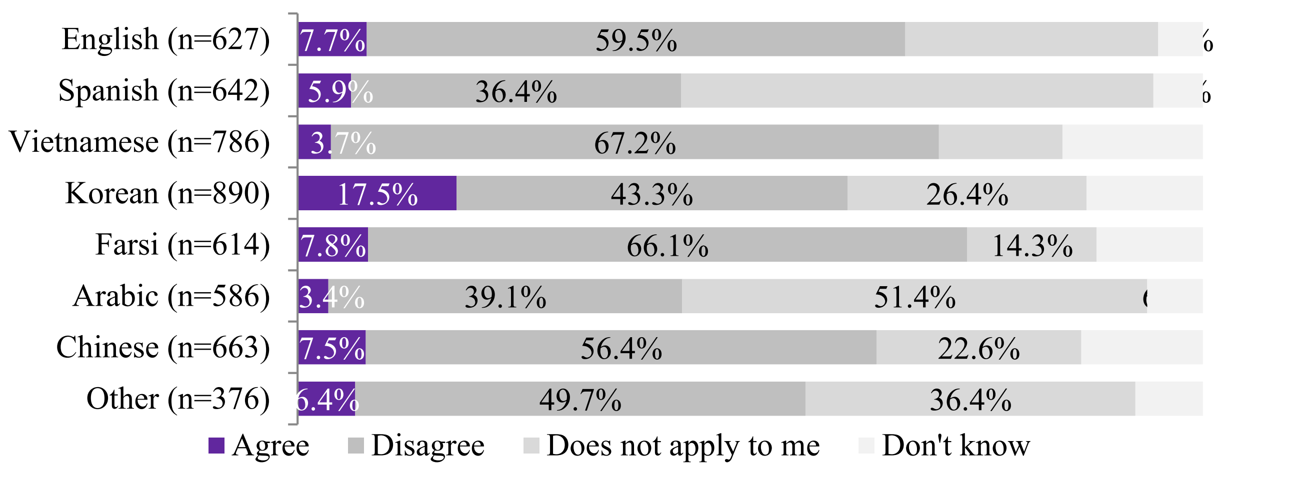



**Region:**

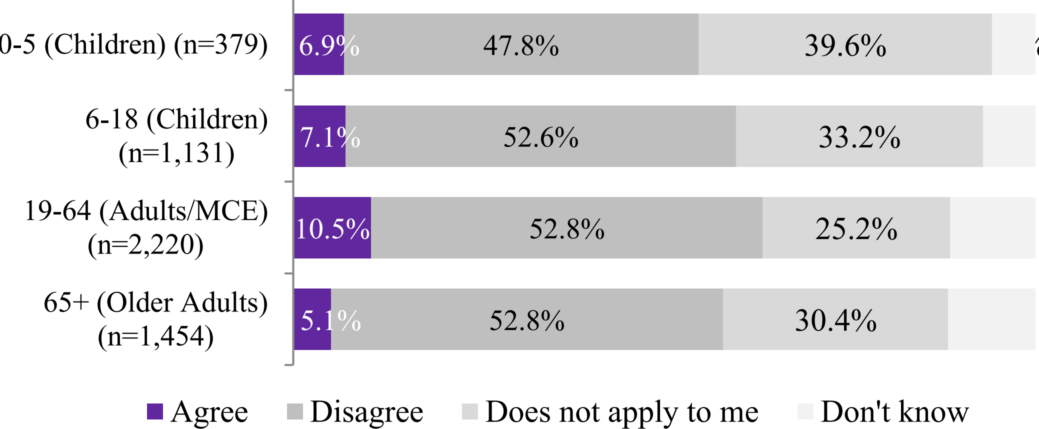


**Feel not treated equally because of ethnic and culutral backgrounds:**

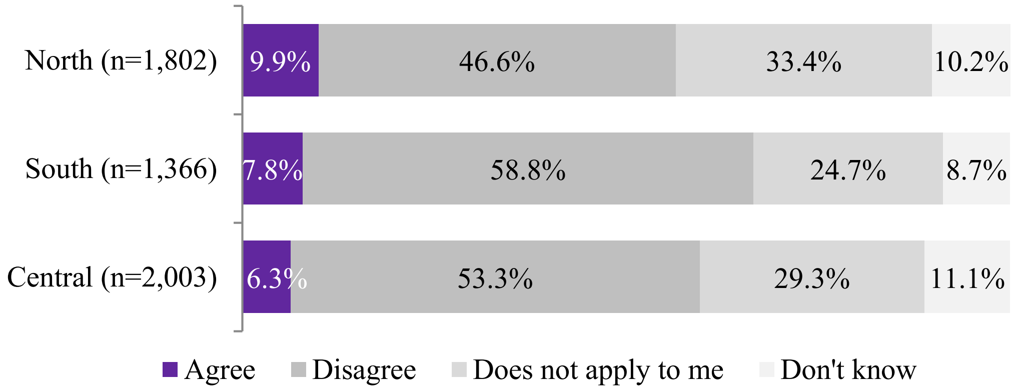
**CalOptima language:**




**Age Category:**

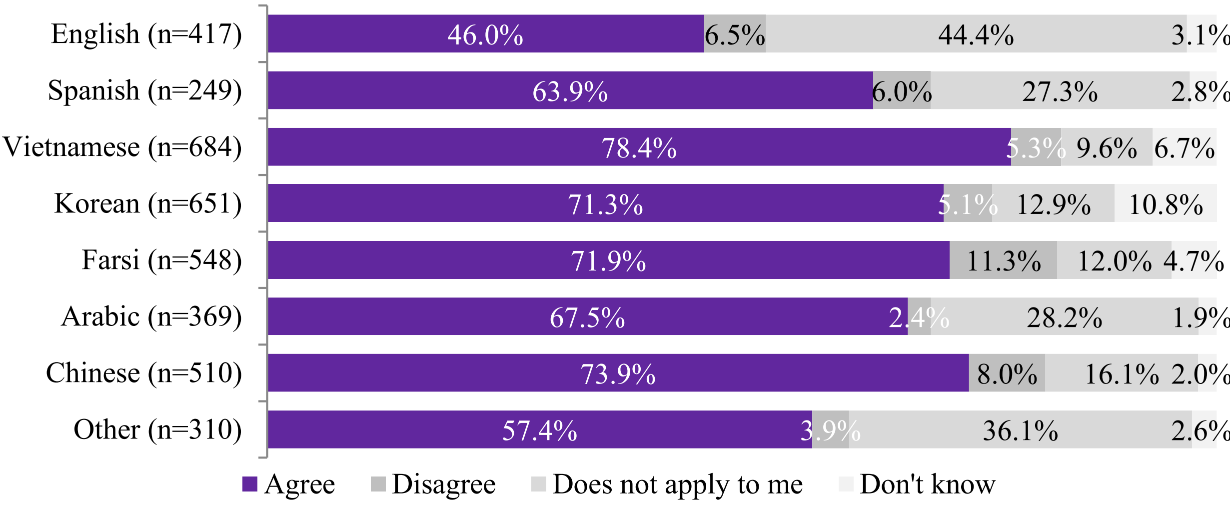



**Region:**



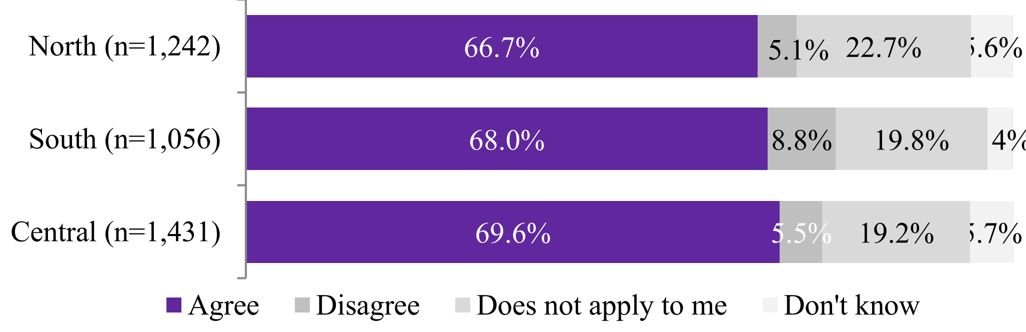
**Feel child respects them as a parent[9]:**

**CalOptima language:**




**Age Category:**

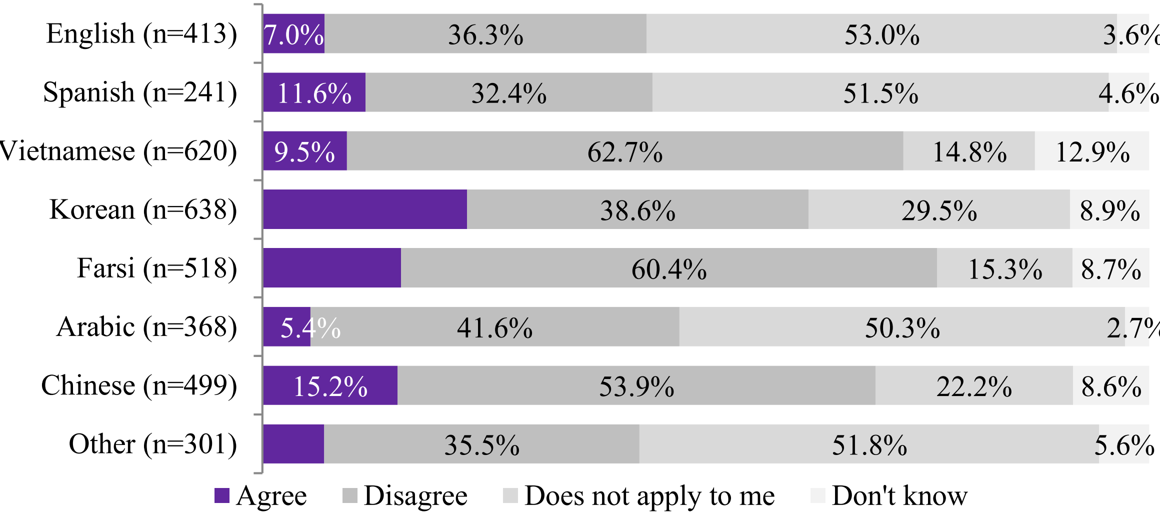
**Region:**



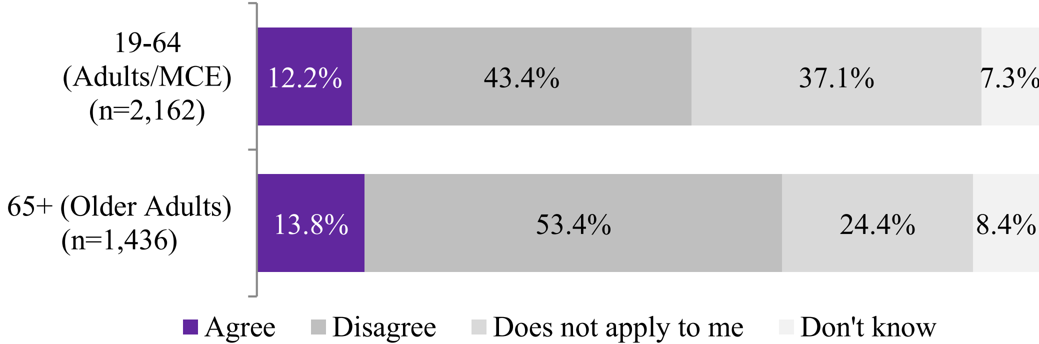

[9] Only reported those who are over 18 years old.

**Feel child's attitudes and behavior conflict with cultural values[10]:**

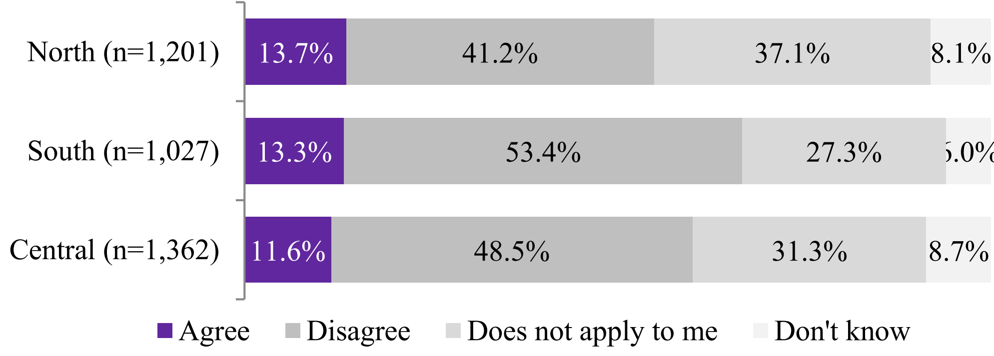
**CalOptima language:**




**Age Category:**



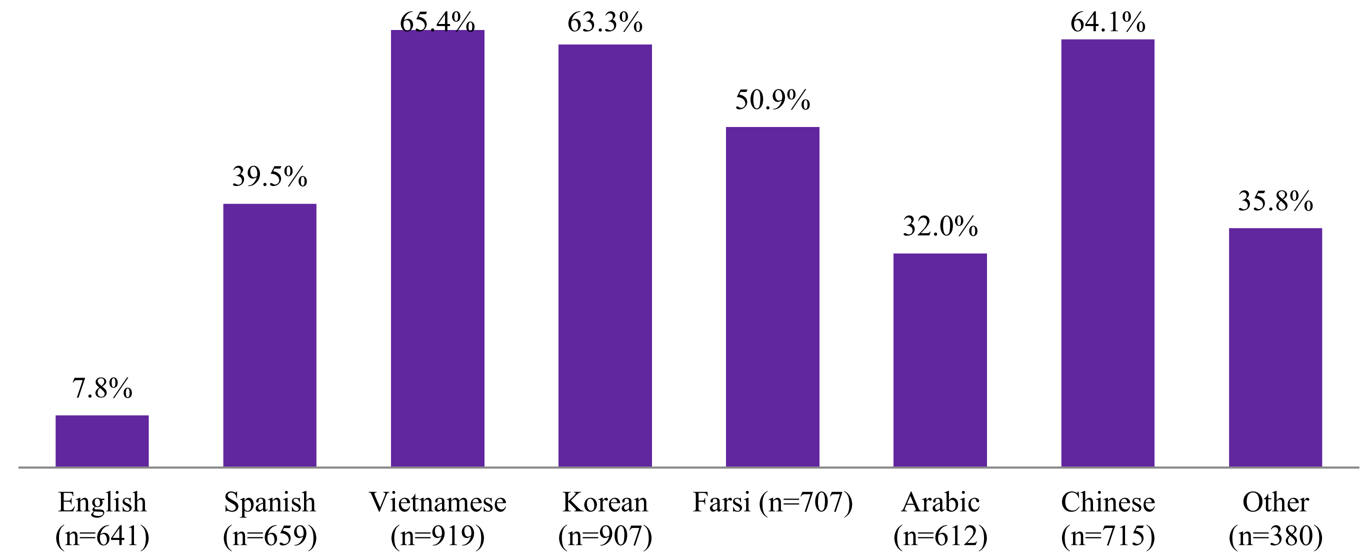

**Region:**



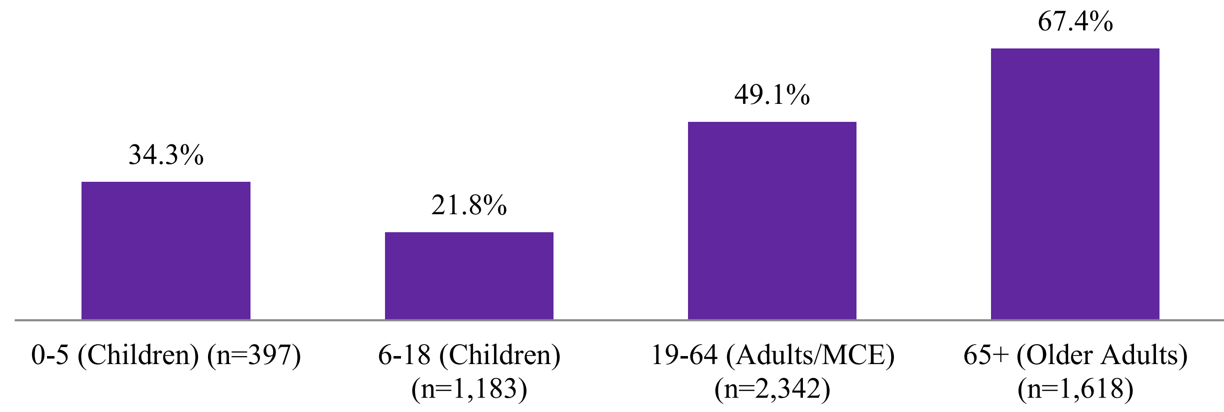

[10] Only reported those who are over 18 years old.

**Exhibit 17. Members who reported that they speak English "not well":**

**CalOptima language:**




**Age Category:**




**Region:**

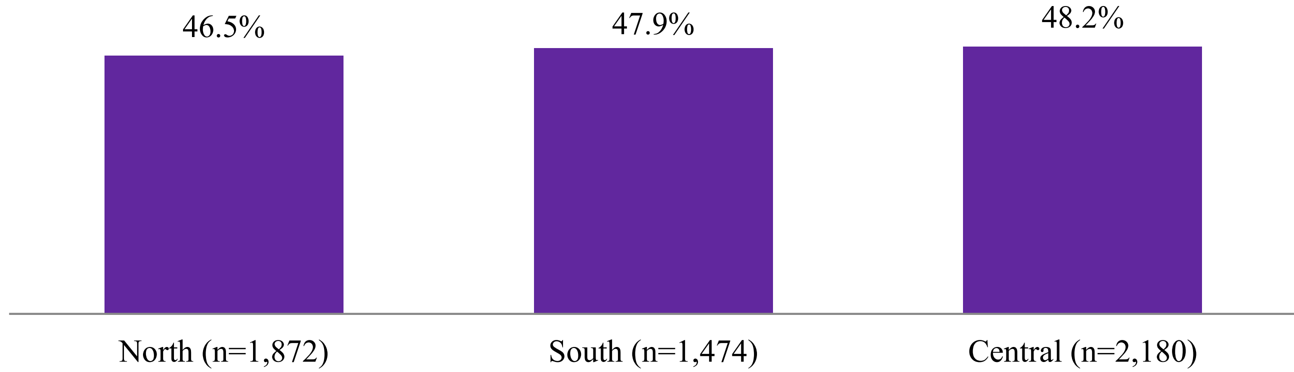


**Exhibit 18. Employment status[11,12]**

**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:**

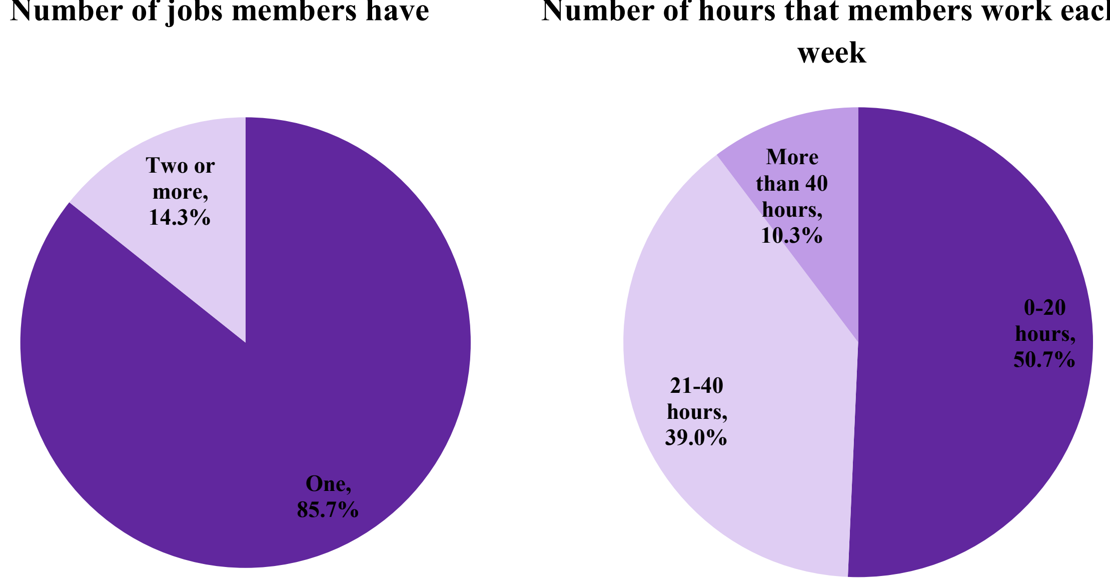
| Age Category | Employed % | Self employed % | Homemaker % | Student % | Retired % | Out of work % | Unable to work % | n |
|---|---|---|---|---|---|---|---|---|
| **19-64 (Adults/MCE)** | 35.8% | 8.3% | 17.5% | 10.9% | 5.9% | 17.6% | 15.3% | 2,370 |
| **65+ (Older Adults)** | 4.1% | 1.7% | 10.1% | 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 |

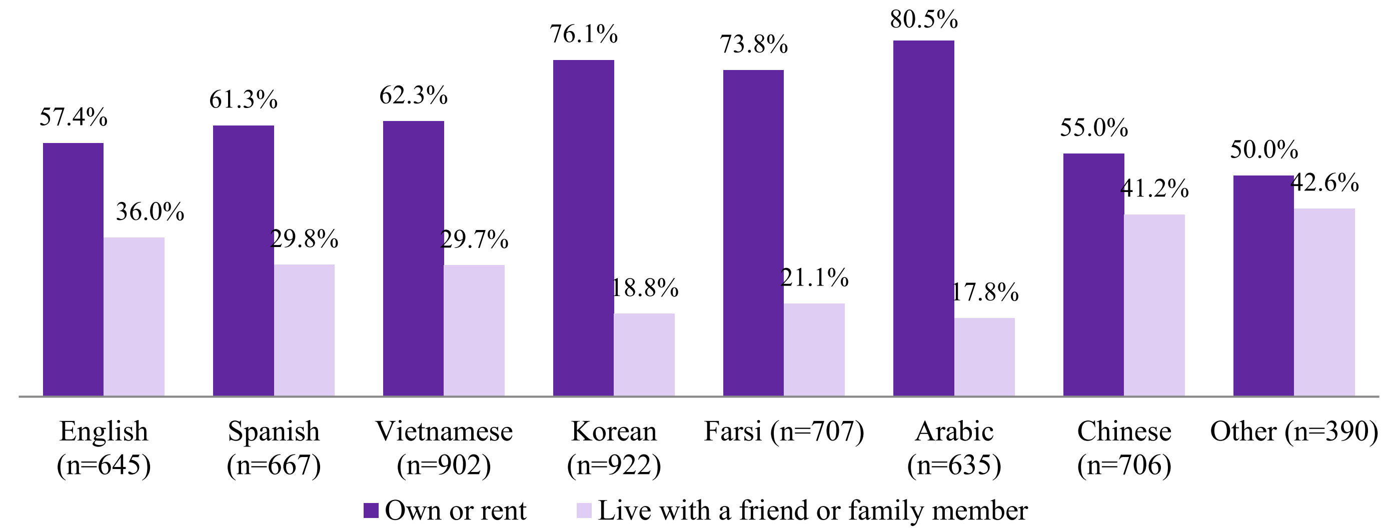
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

**Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]**

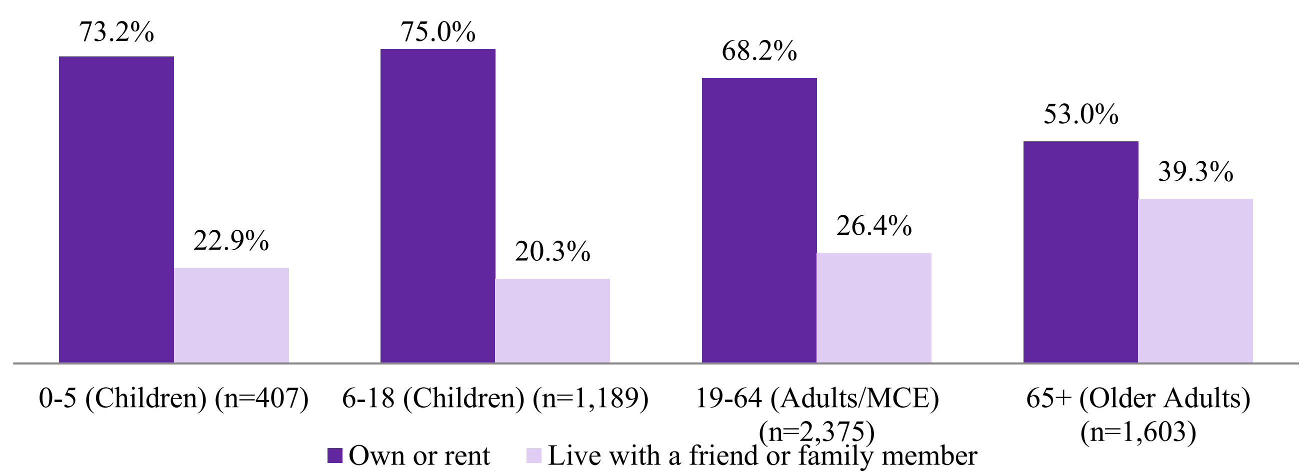



[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

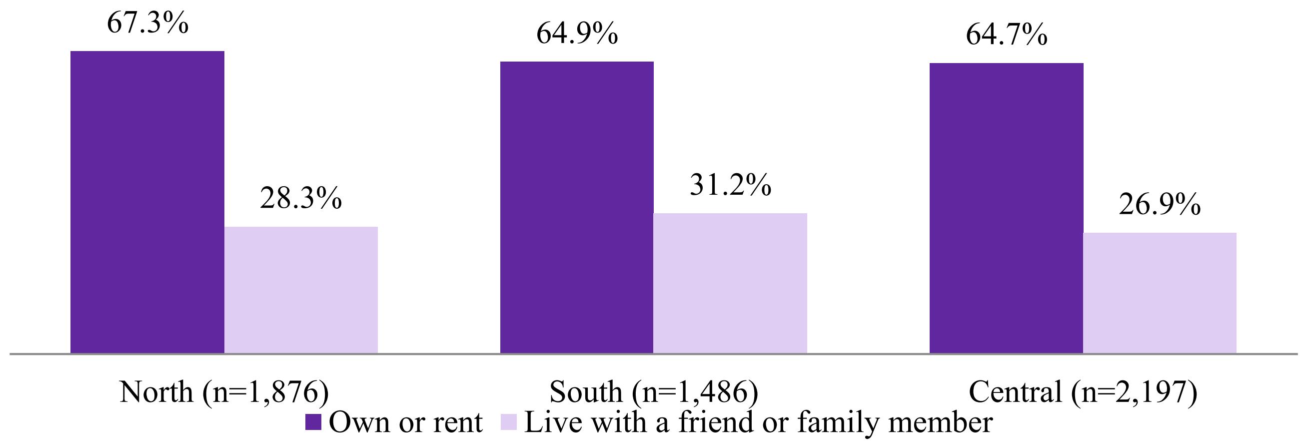
**Exhibit 20. Members' living situation[14]**




**Age Category:**



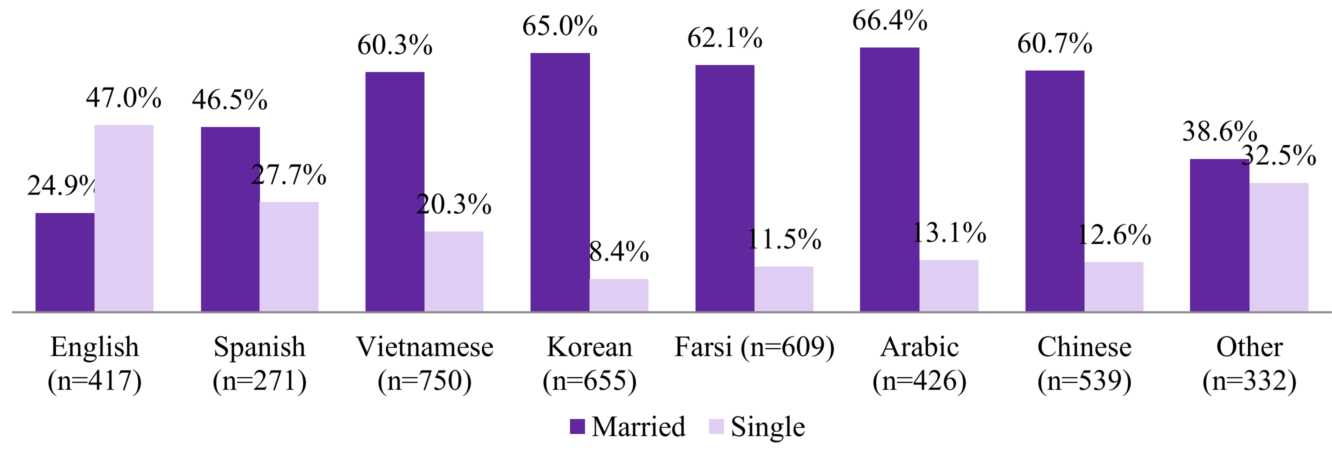

**Region:**



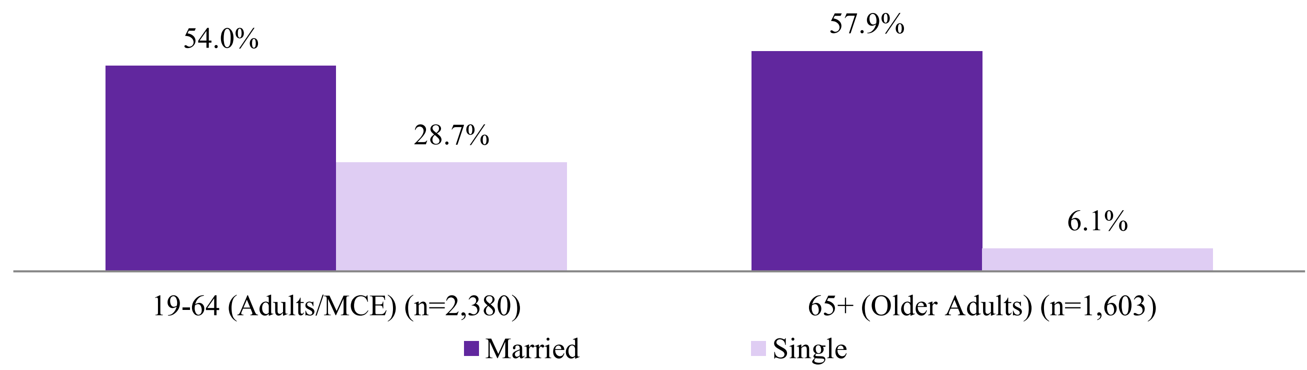

[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

**Exhibit 21. Marital status of members[15],[16]**

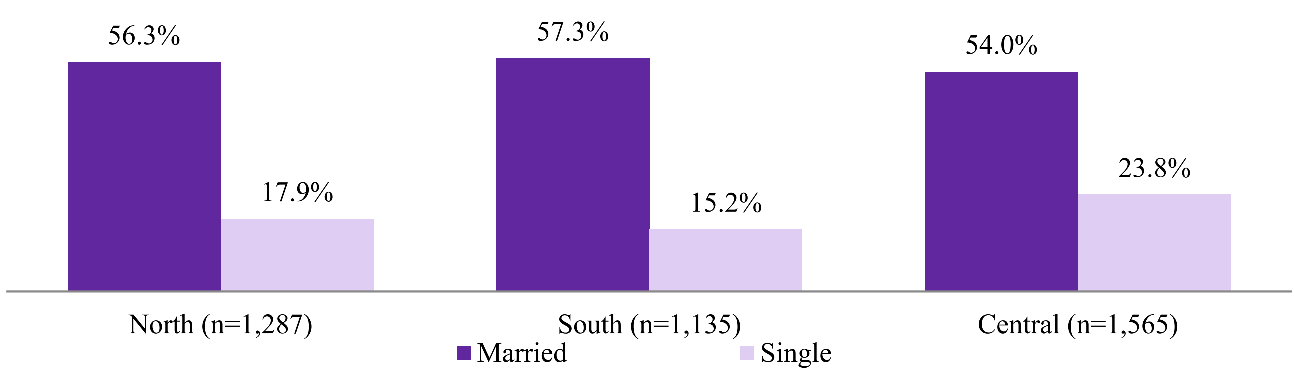
**CalOptima language:**




**Age Category:**



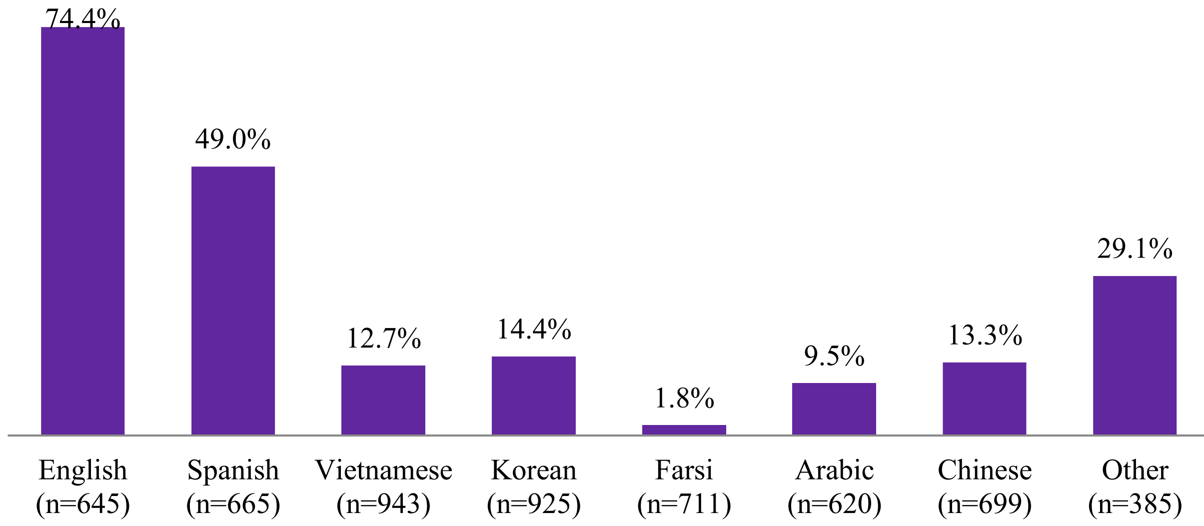

**Region:**



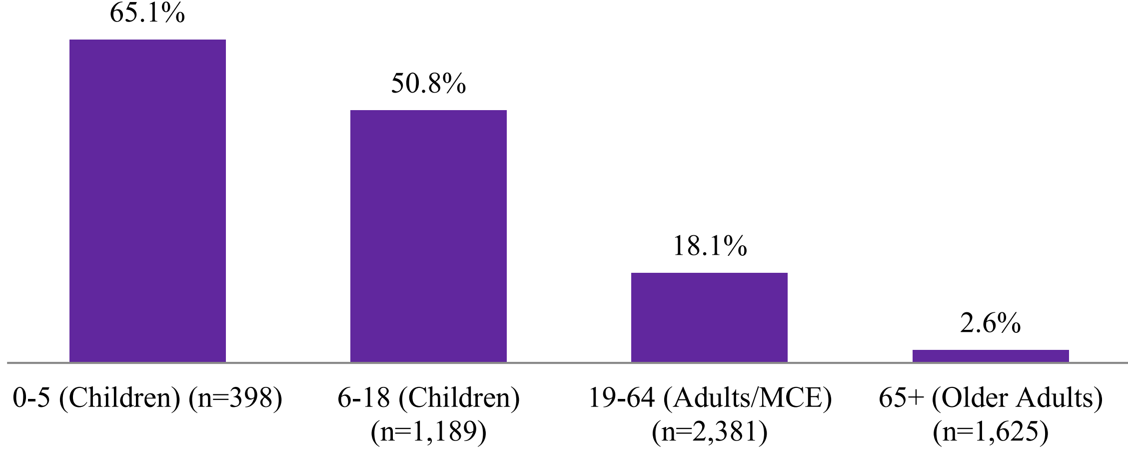

[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

**Exhibit 22. Percent of members who were born in the United States:**

**CalOptima language:**




**Age Category:**




**Region:**

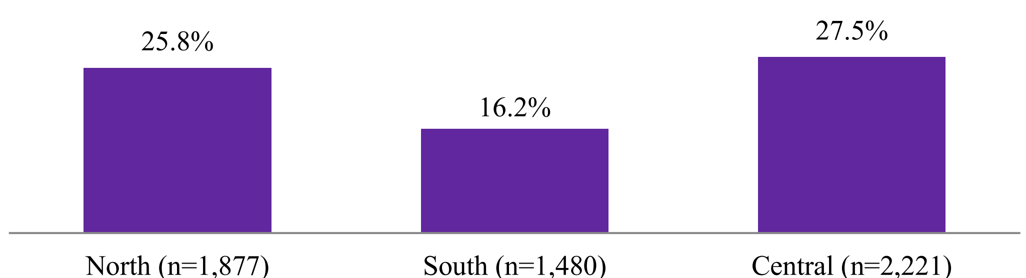
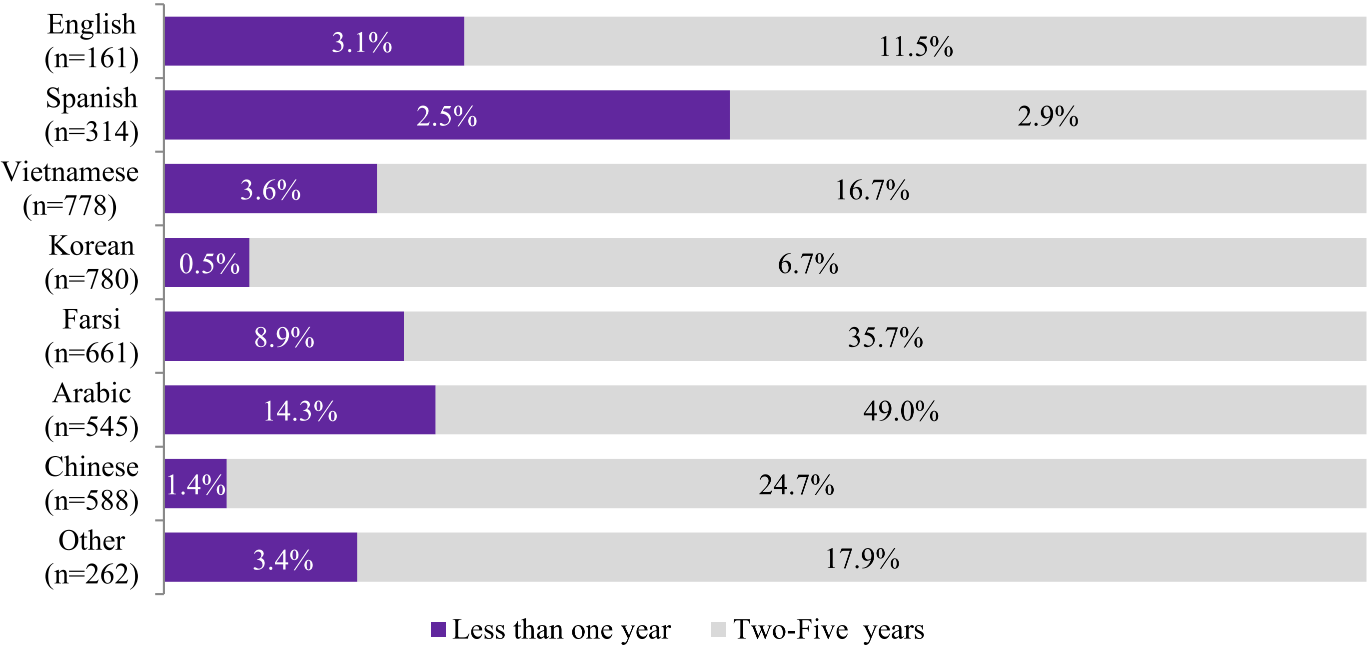
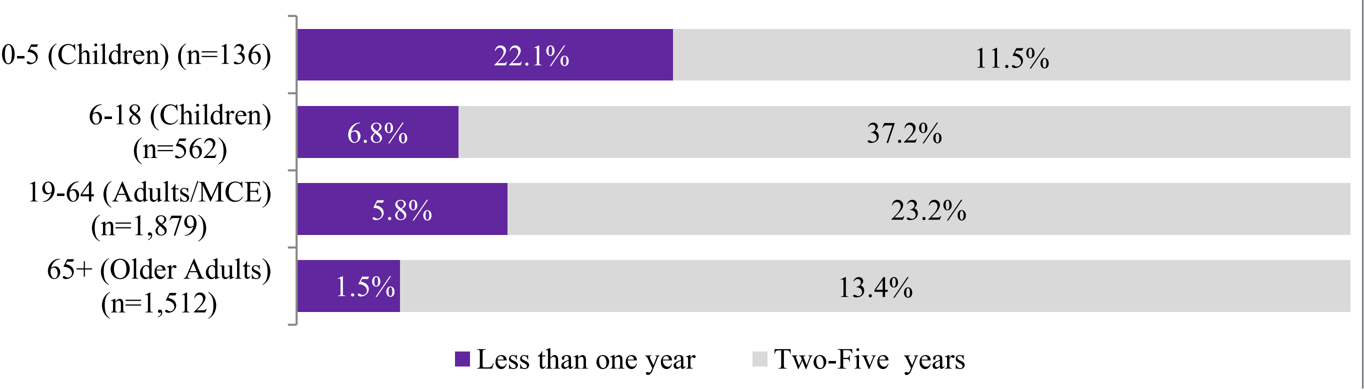


**Exhibit 23. Length of time lived in the United States of those not born in the United States**

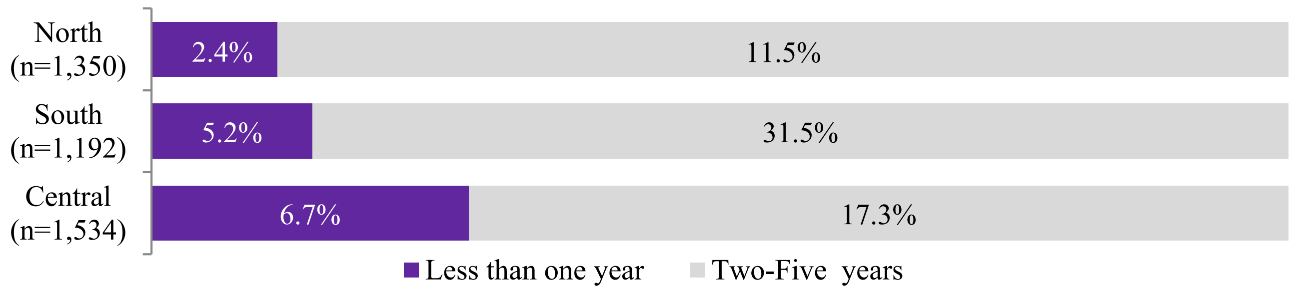
**CalOptima language:**




**Age Category:**



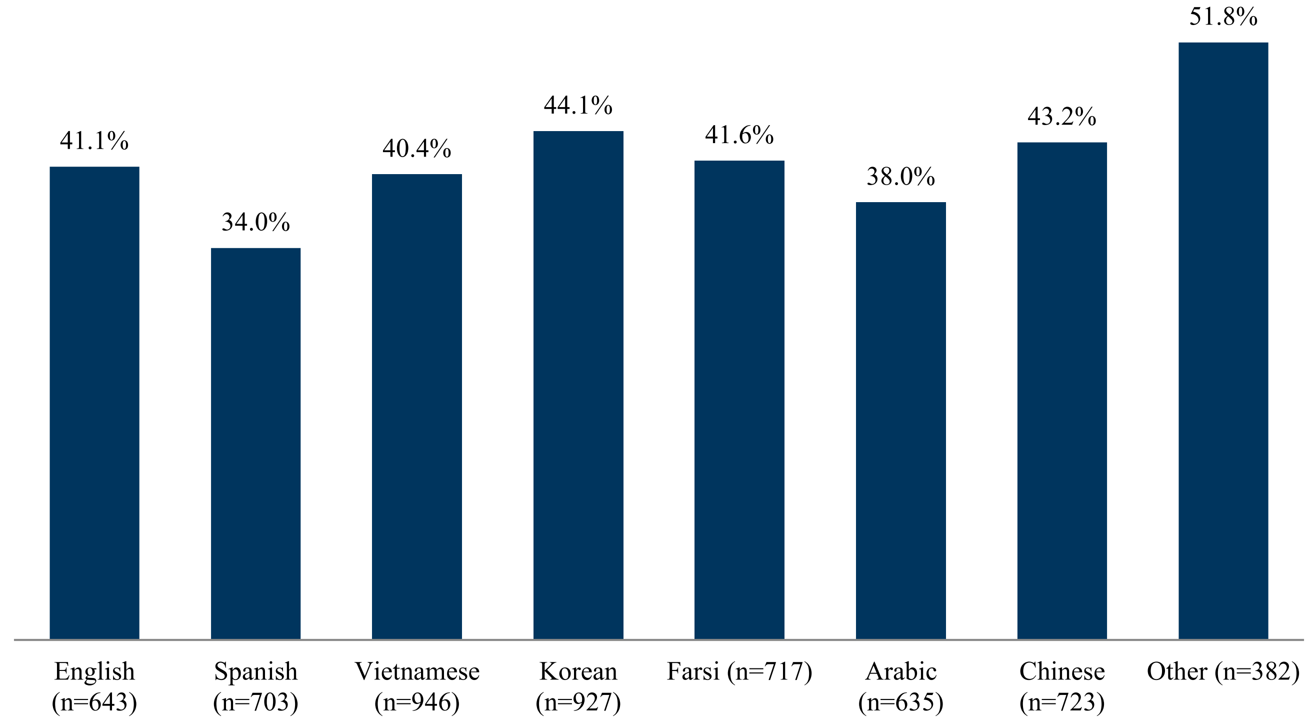

**Region:**



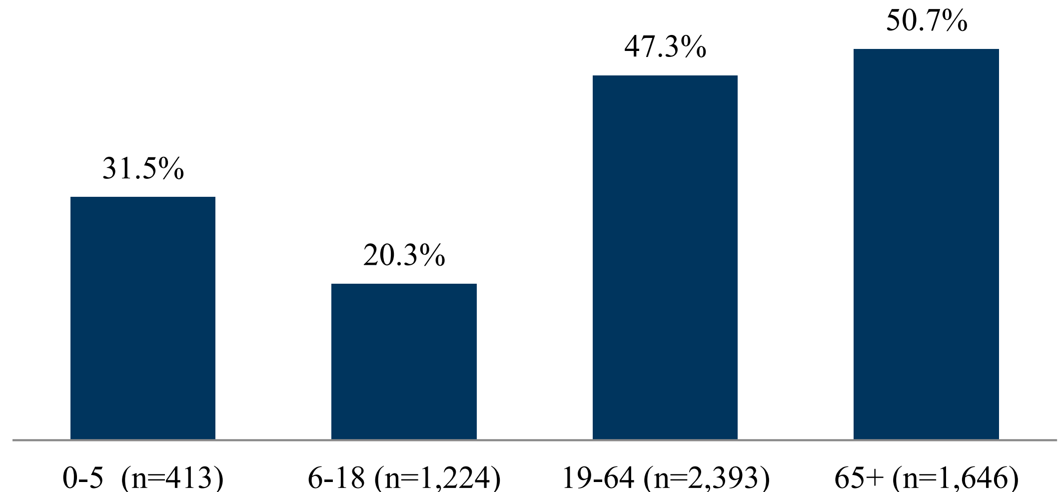
# Health Behaviors

**Exhibit 24. Percent of members who have not seen a dentist within the past 12 months**

**CalOptima language:**




**Age Category:**



**Region:**

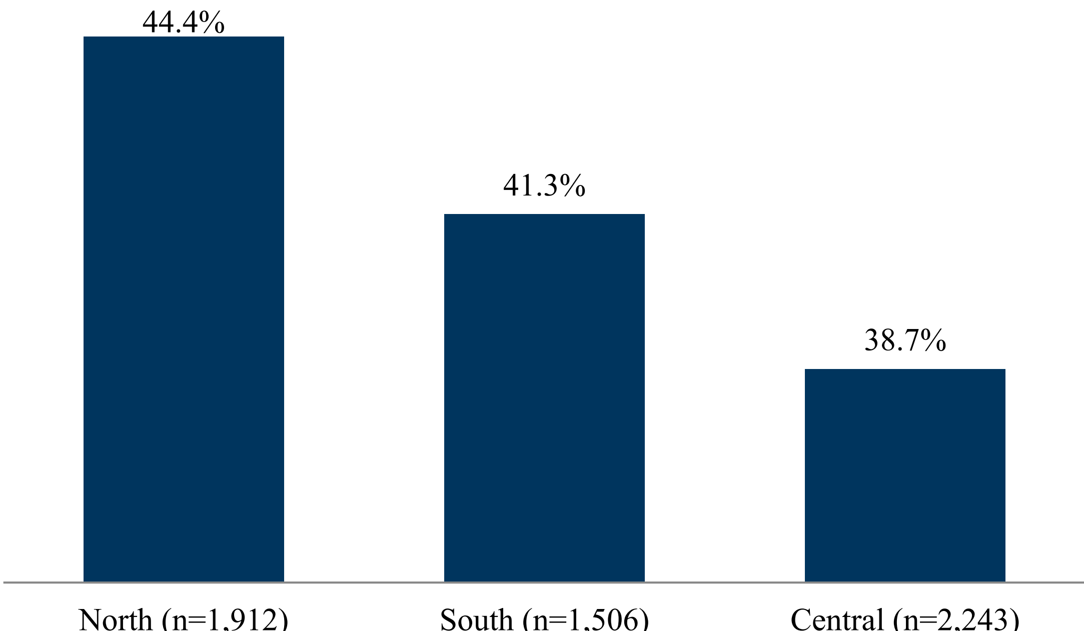


**Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]**

**CalOptima Language:**

| CalOptima Language | Cost<br>% | Don't have/know dentist<br>% | No transportation<br>% | Don't know<br>% | 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<br>% | Don't have/know dentist<br>% | No transportation<br>% | Don't know<br>% | 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<br>% | Don't have/know dentist<br>% | No transportation<br>% | Don't know<br>% | 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<br>% | 1 2 days per week<br>% | 3 4 days per week<br>% | 5 7 days per week<br>% | Don't know<br>% | 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<br>% | 1 2 days per week<br>% | 3 4 days per week<br>% | 5 7 days per week<br>% | Don't know<br>% | 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

# Navigating the Healthcare System

**Exhibit 27. Percent who report at least one person as their doctor (n=5,749)**

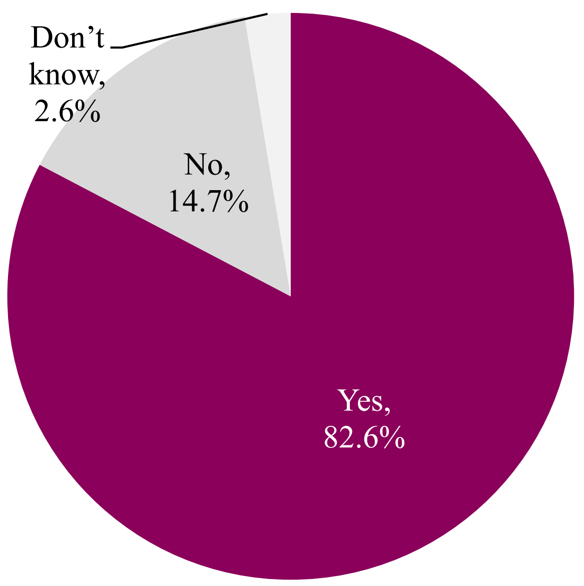



**Exhibit 28. Where respondents go to see their doctor (n=5,743)**

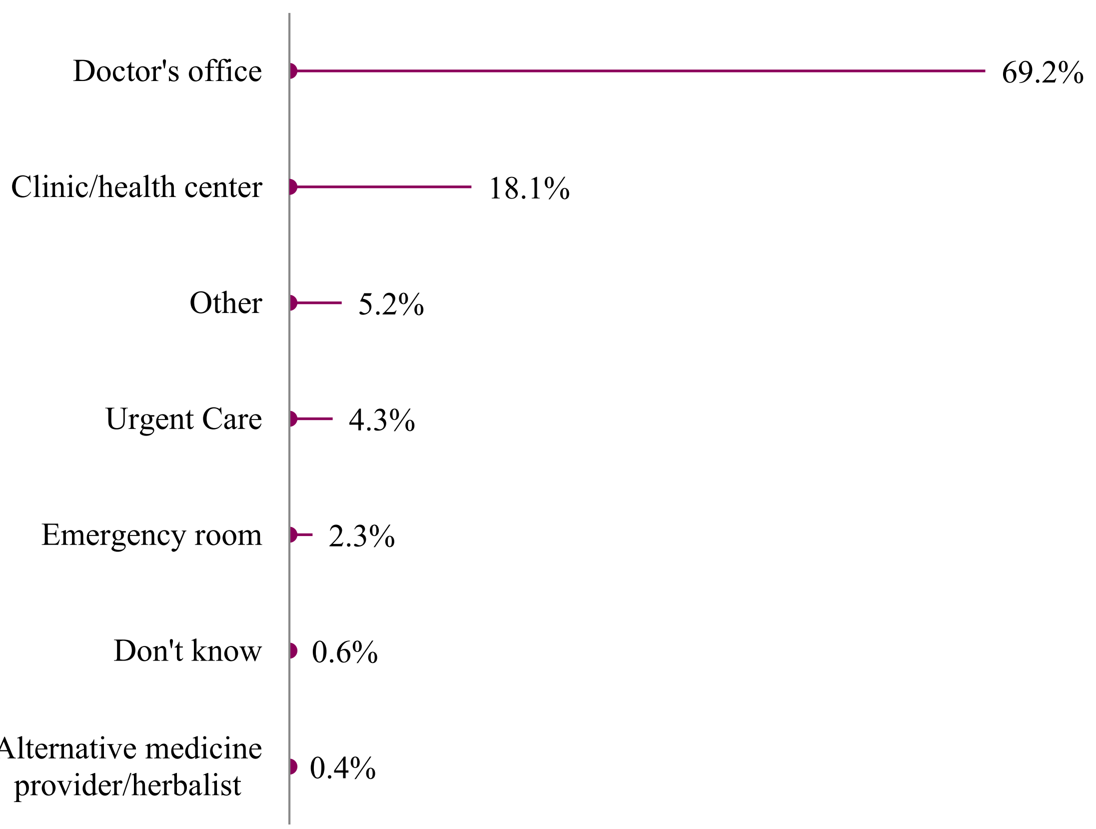


**Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)**

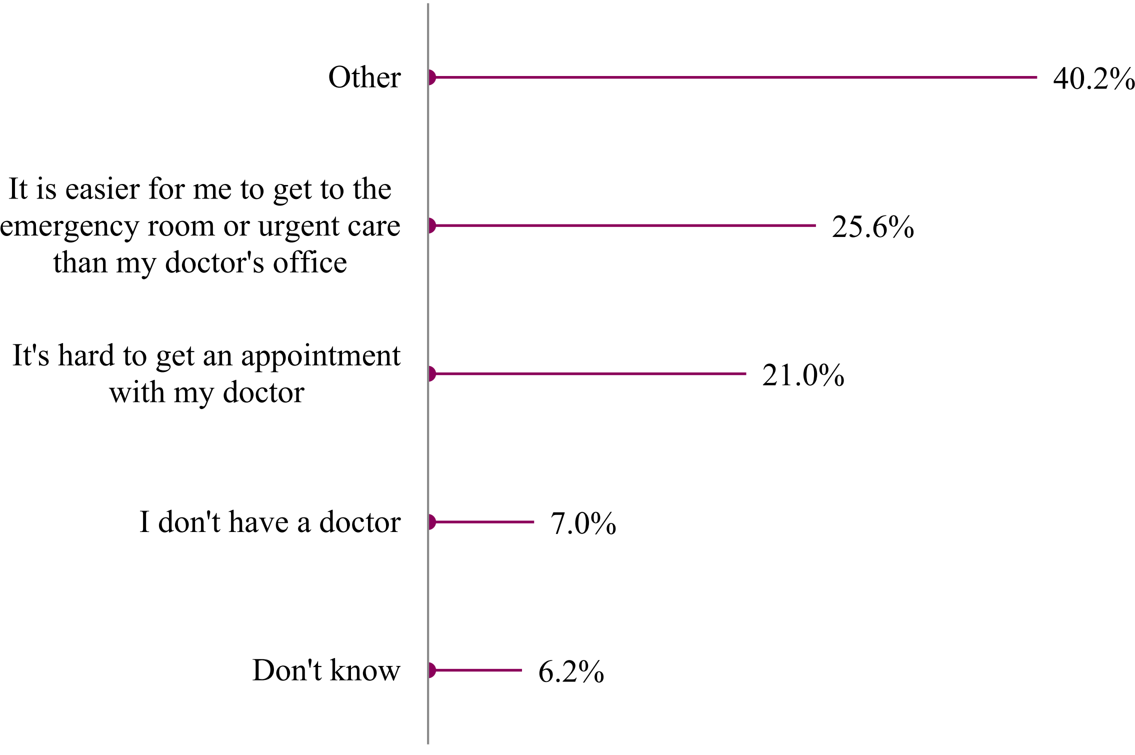


**Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]**

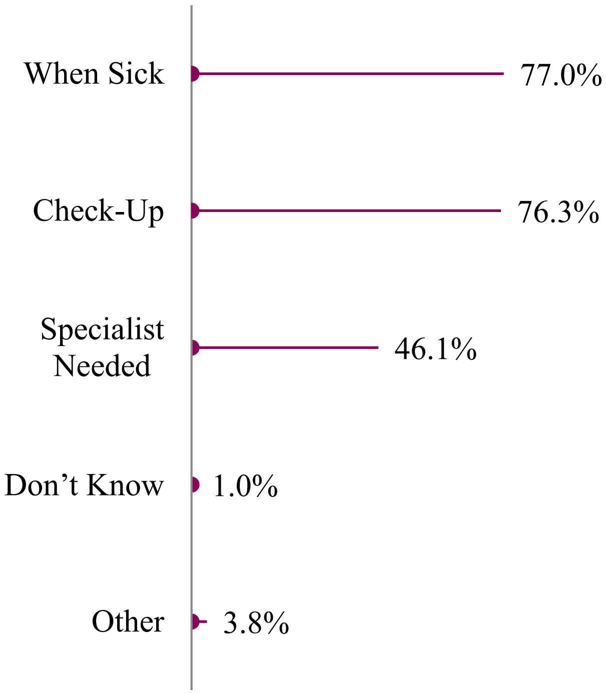
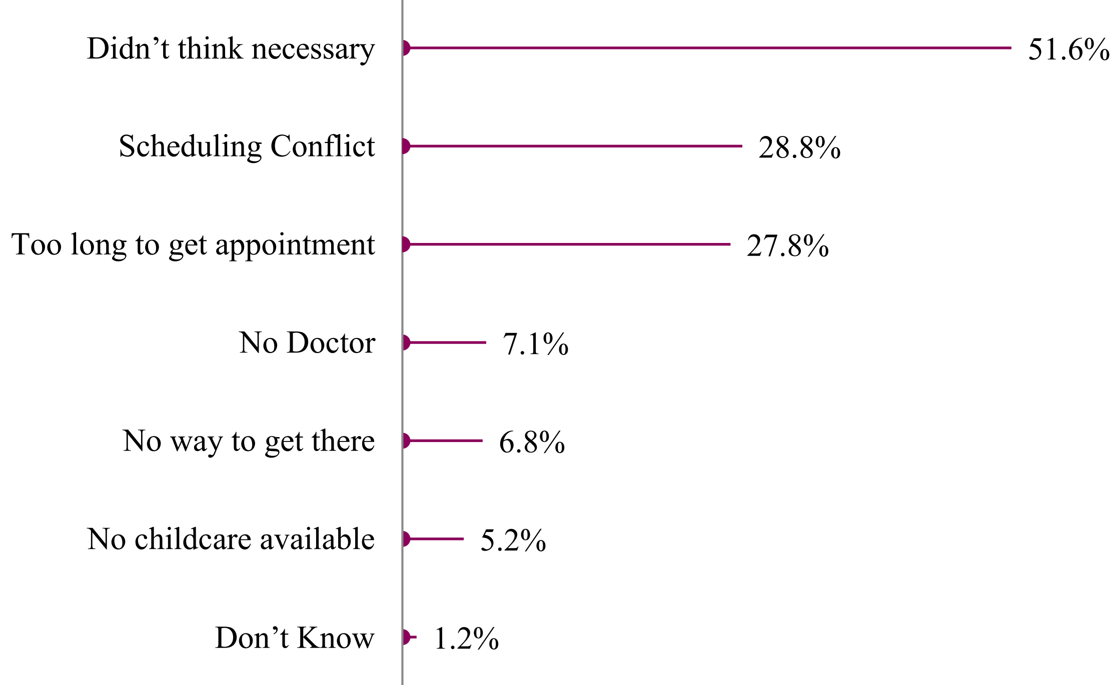



**Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]**




[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%.



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**Exhibit 32. When do members make an appointment to see a specialist (n=5,590)[22]**

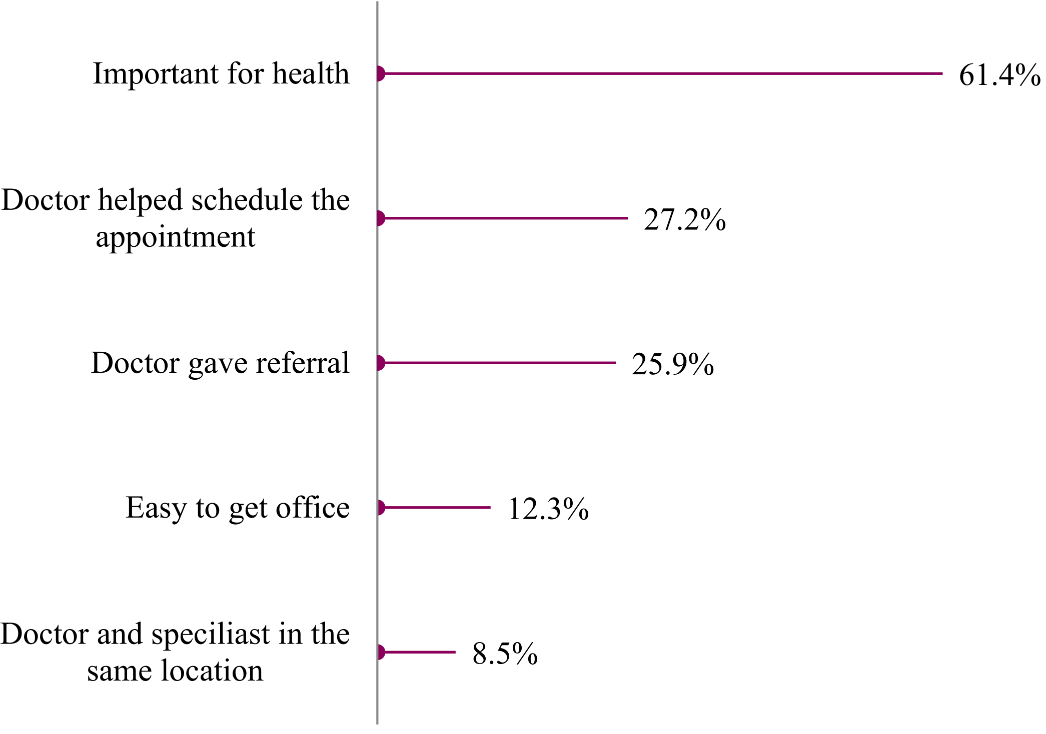
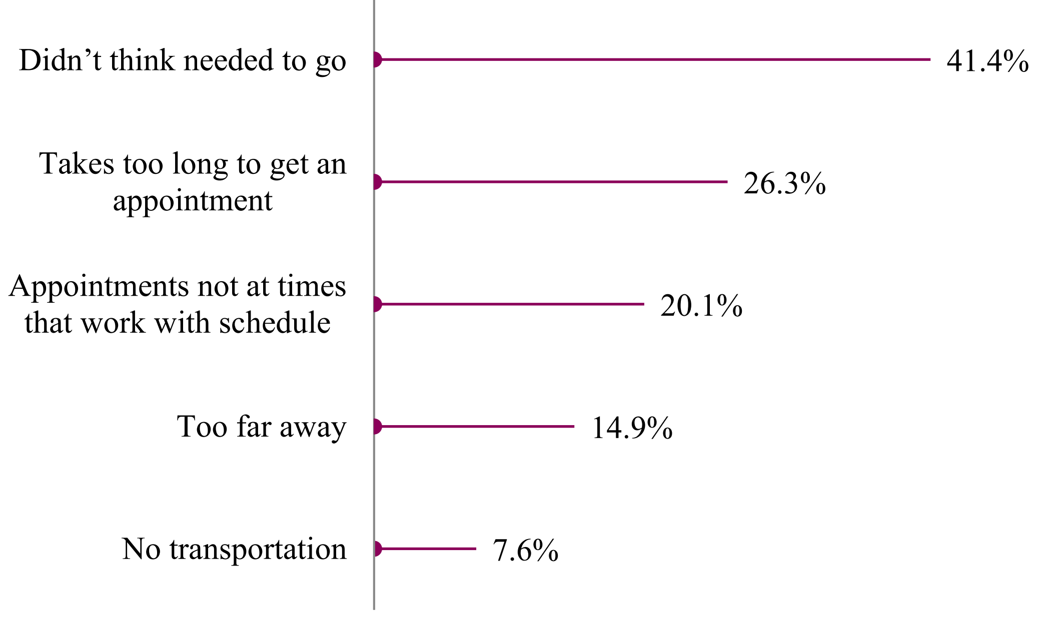



**Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]**




[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%.



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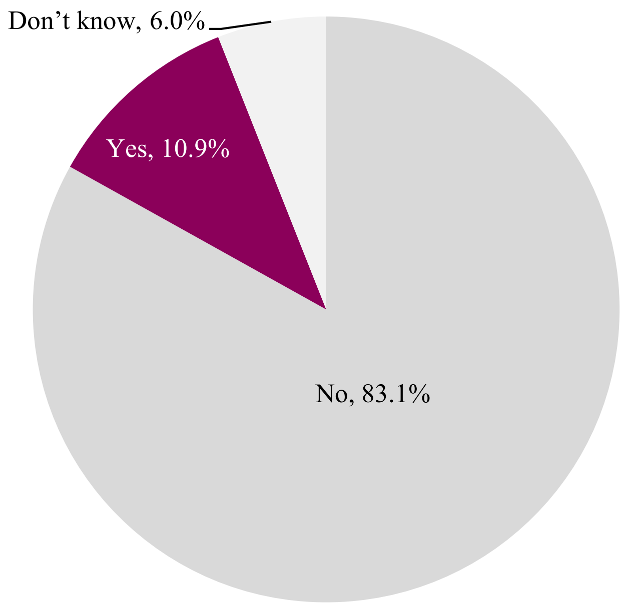
**Exhibit 34. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor (n=4,955)**



# Social and Emotional Well-Being

**Exhibit 35. Percent of members who indicated they needed to see a mental health specialist (n=5,723)**

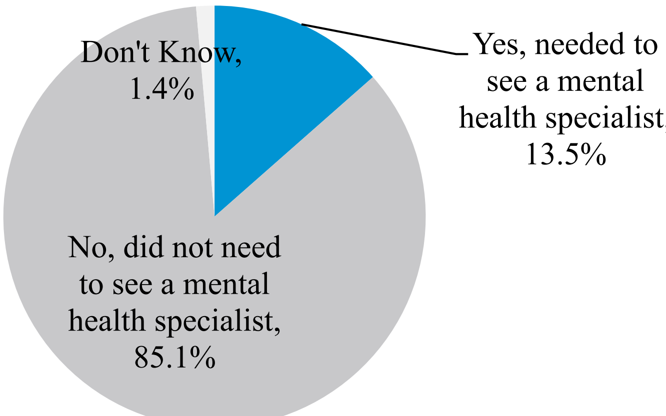



**Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)**

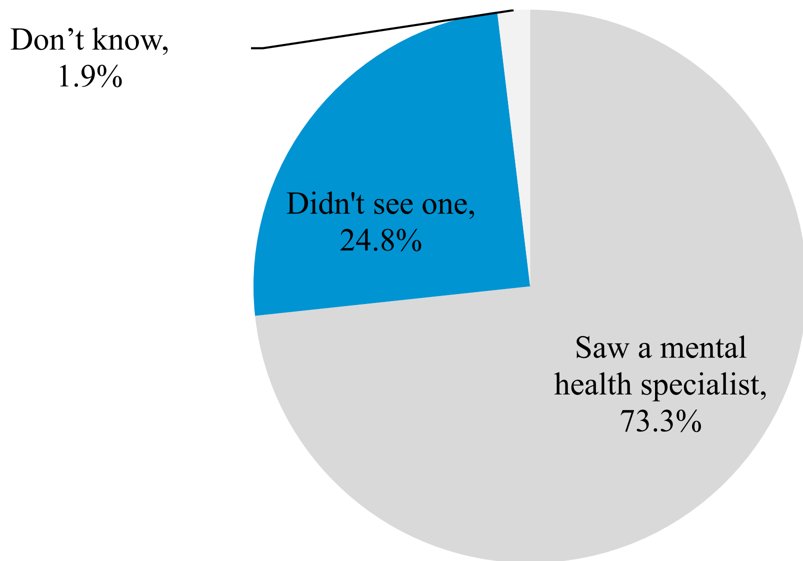


**Exhibit 37. Reasons why members didn't see mental health specialist[24]**

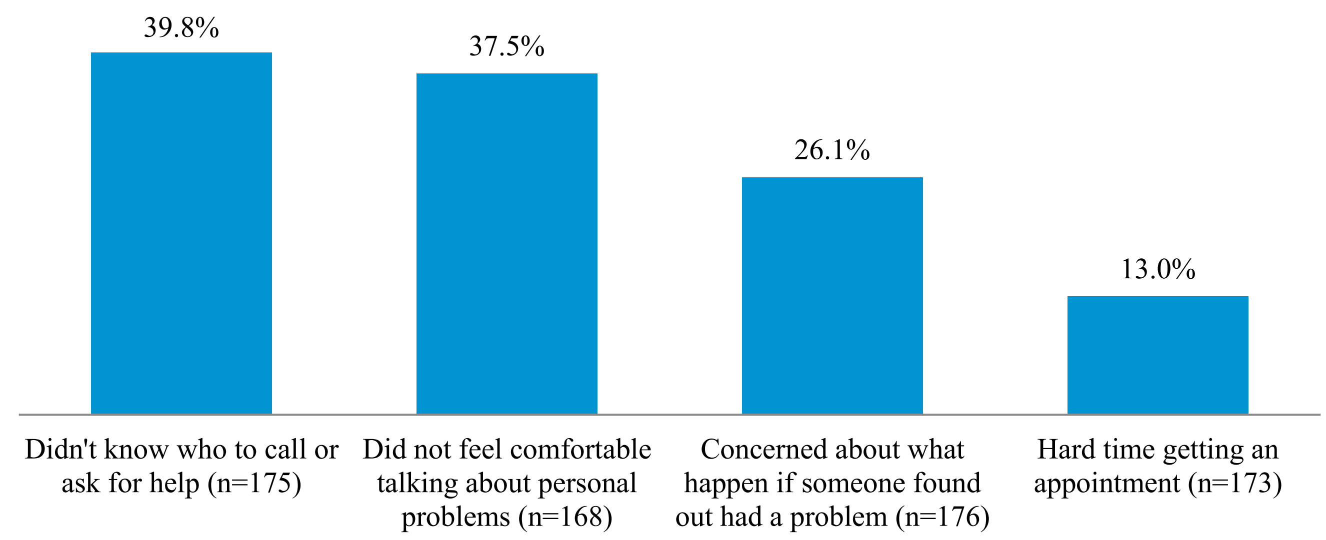
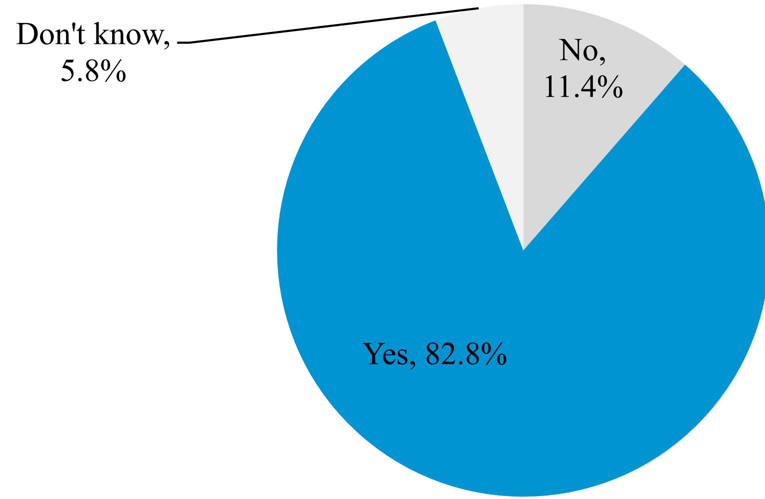



**Exhibit 38. Percent of members who can share their worries with family members (n=5,670)**




[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:**

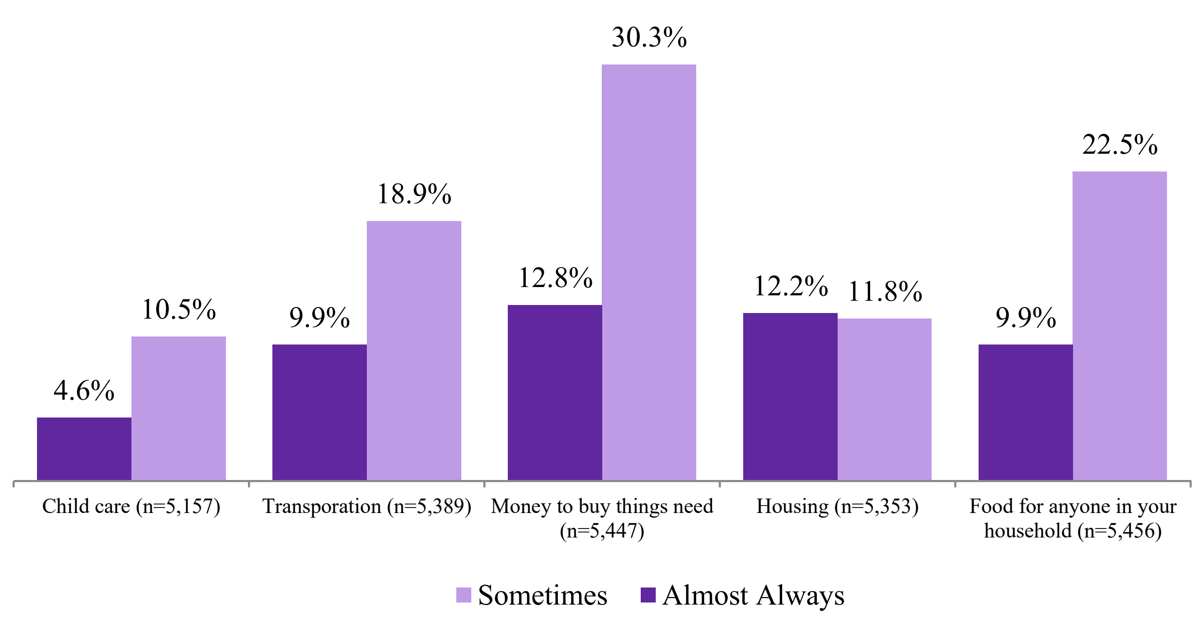


**Exhibit 41. Percent of members who receive public benefits (n=5,117):**

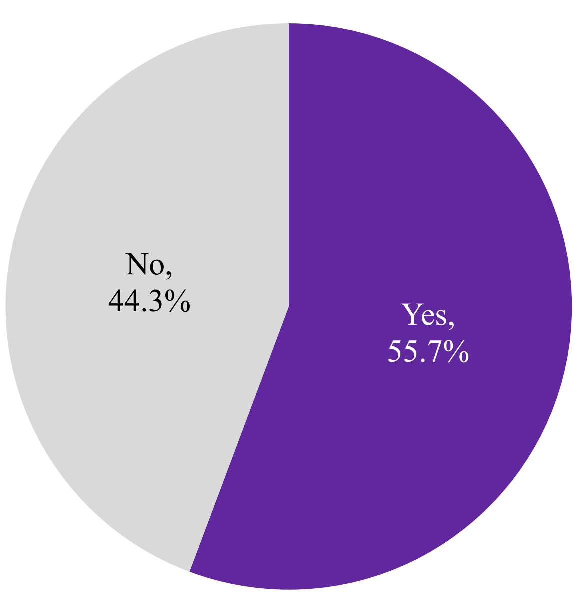
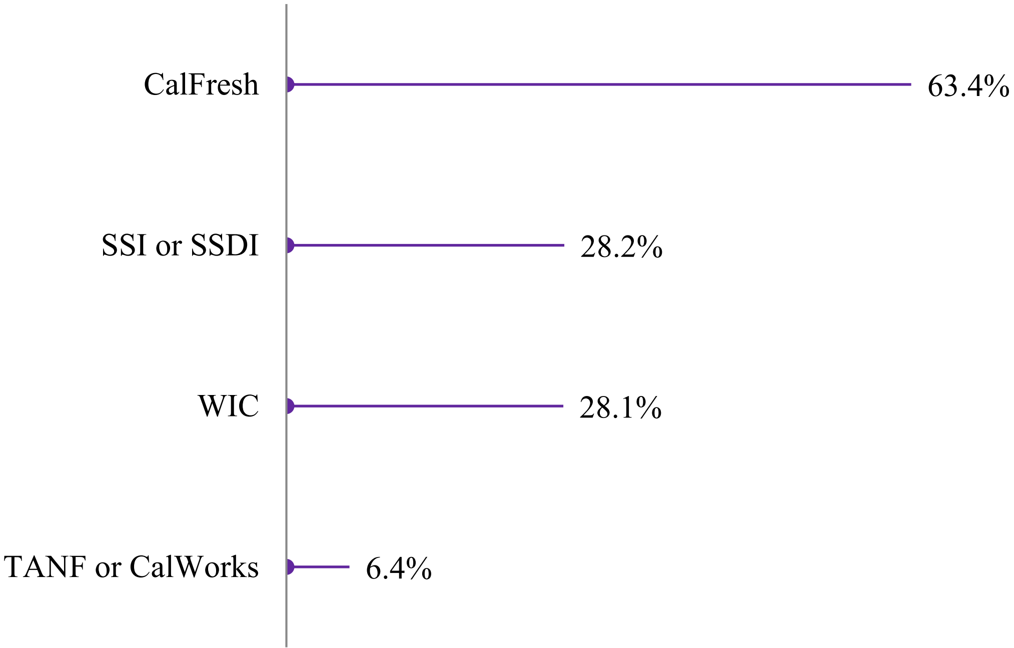



**Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:**

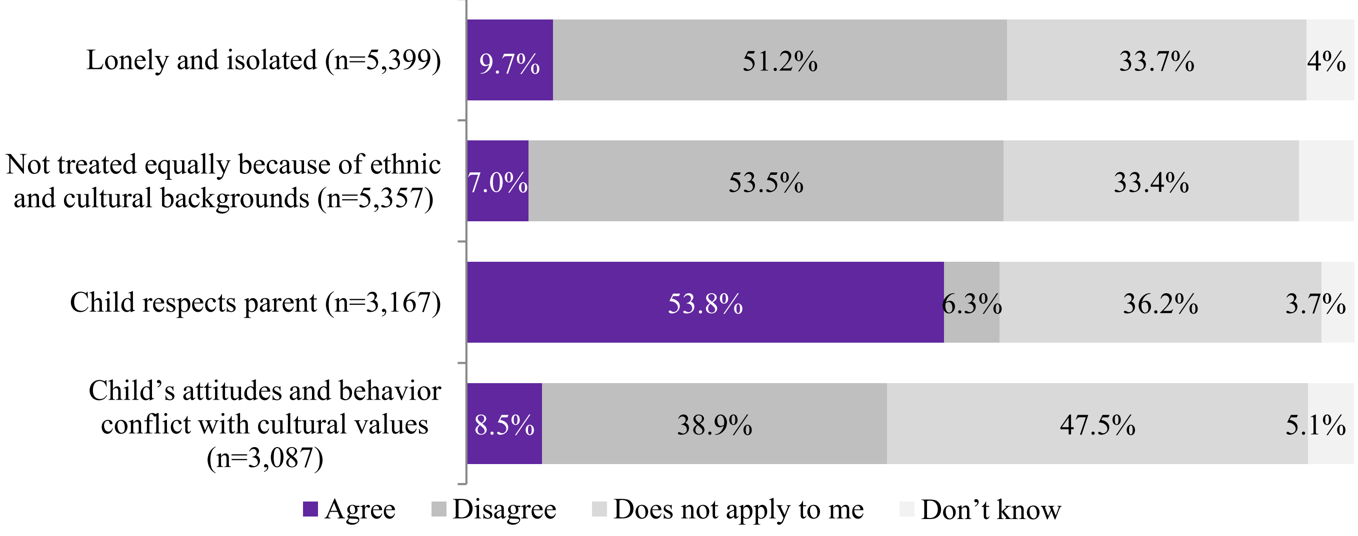



[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

**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% | |
| **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)**

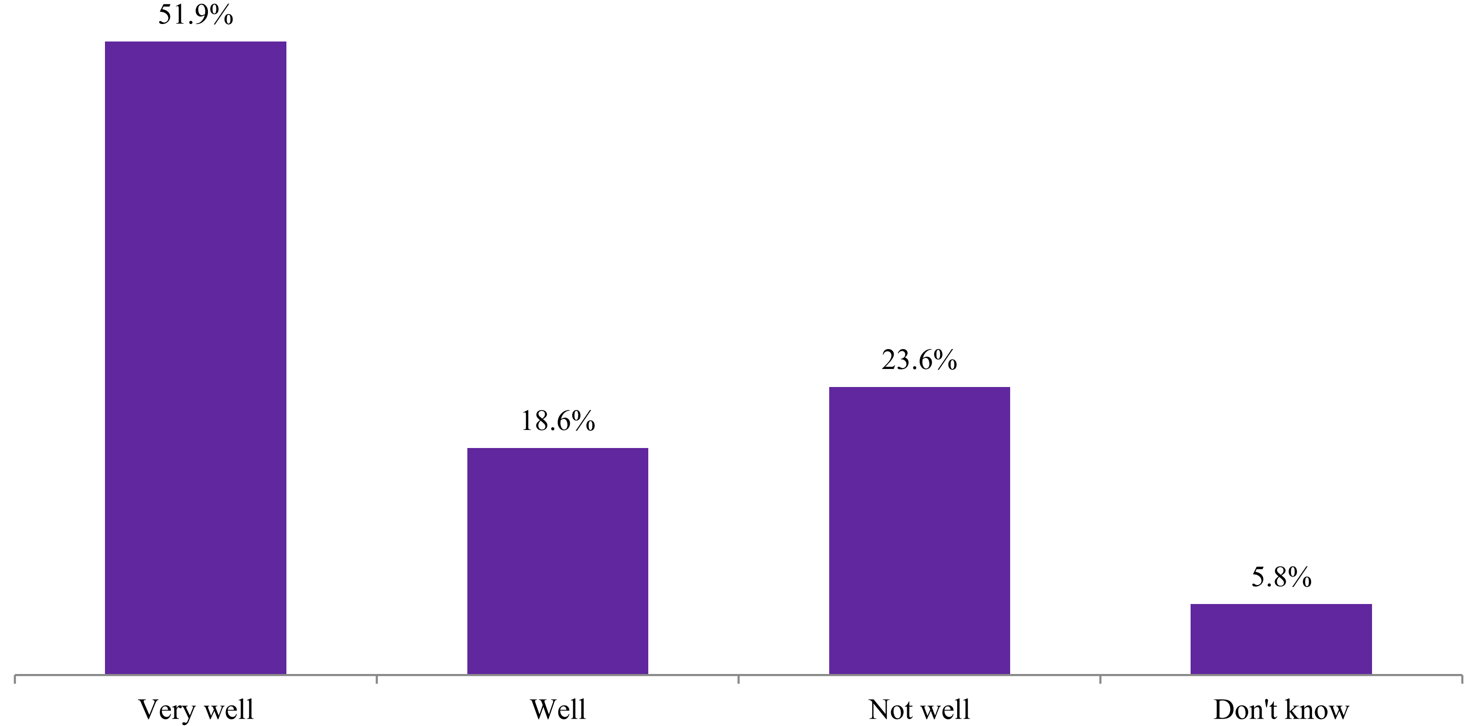


**Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]**

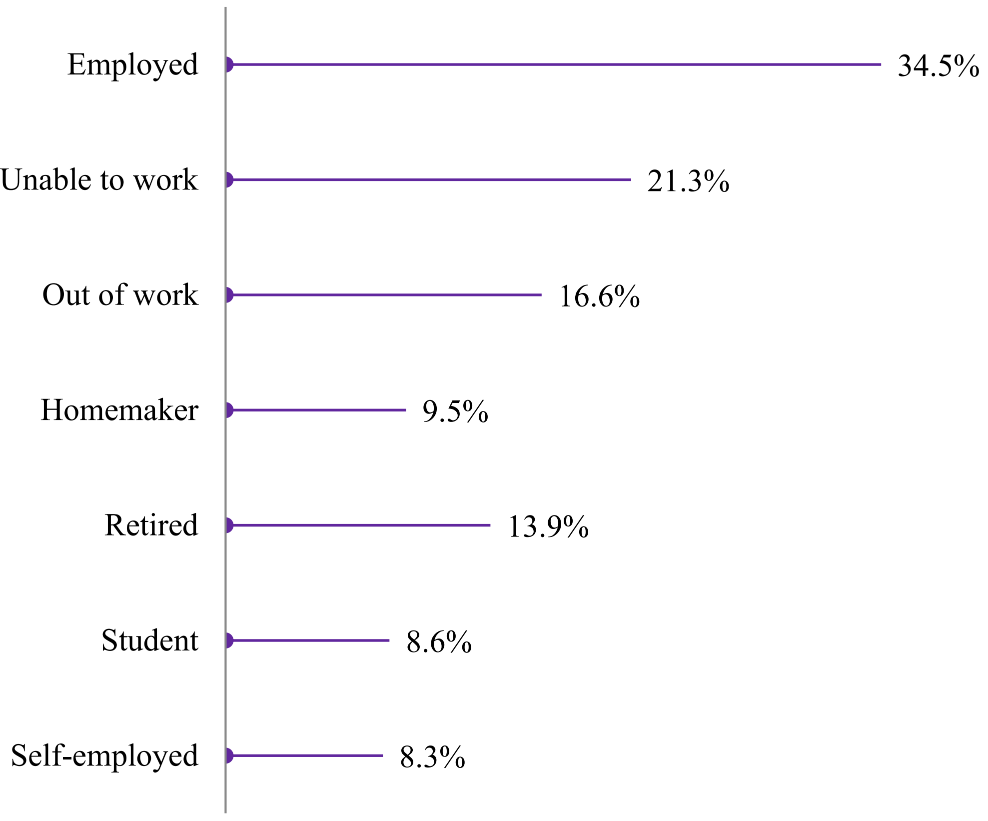
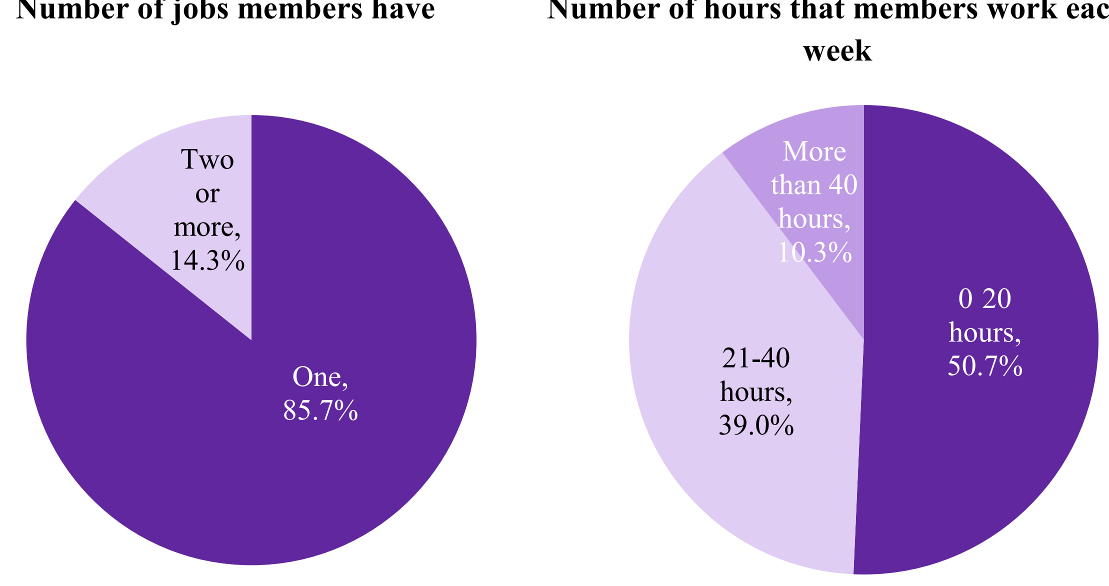



**Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]**




[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)**

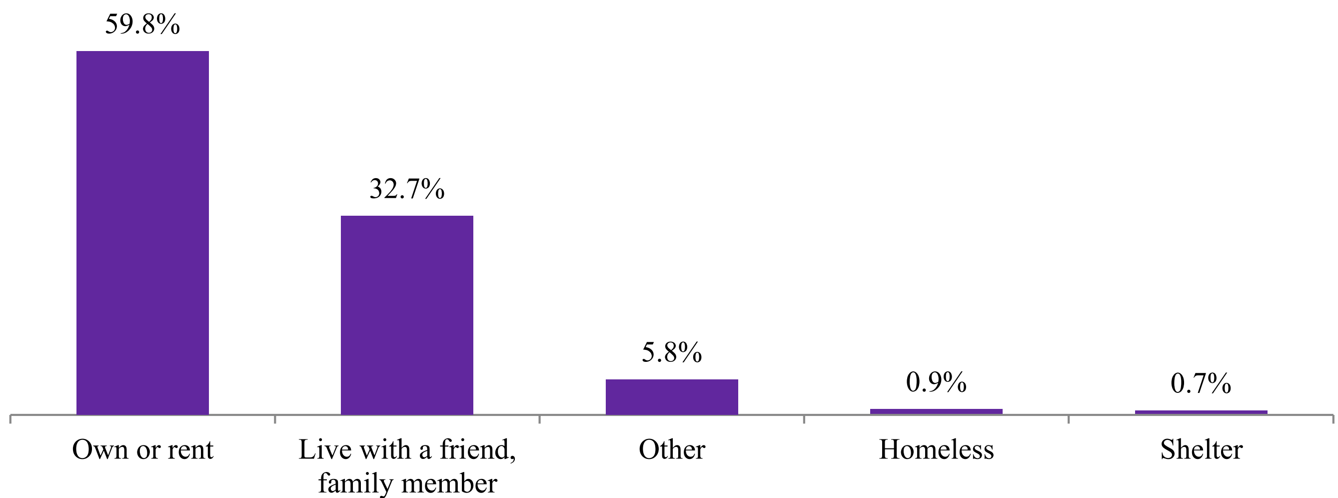
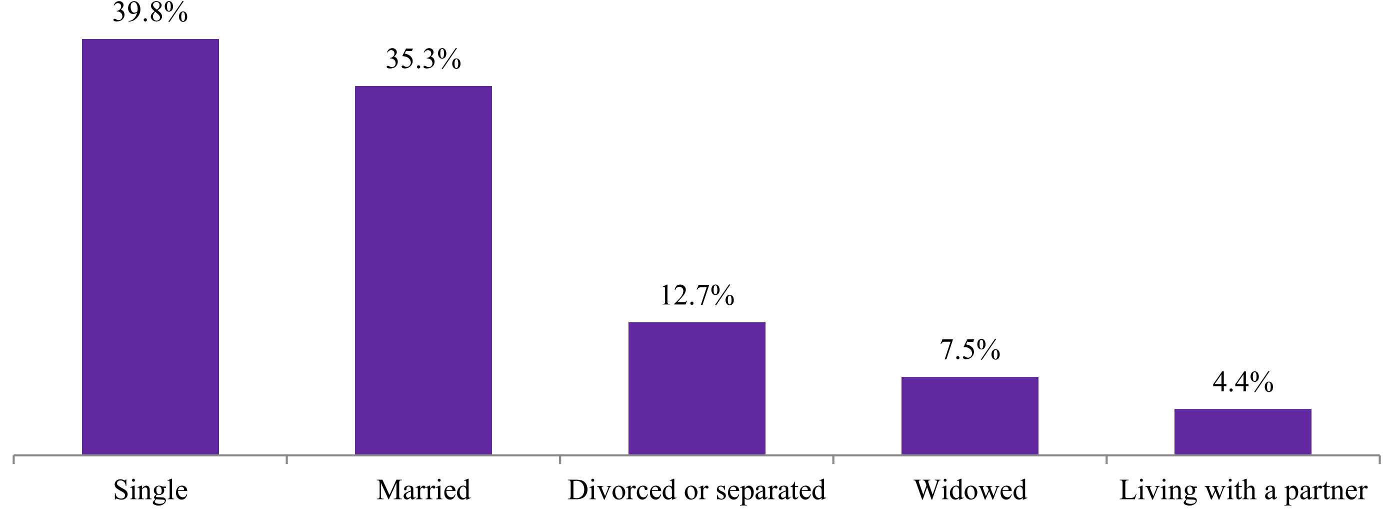



**Exhibit 49. Marital status of members (n=3,271)[30]**




[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)**

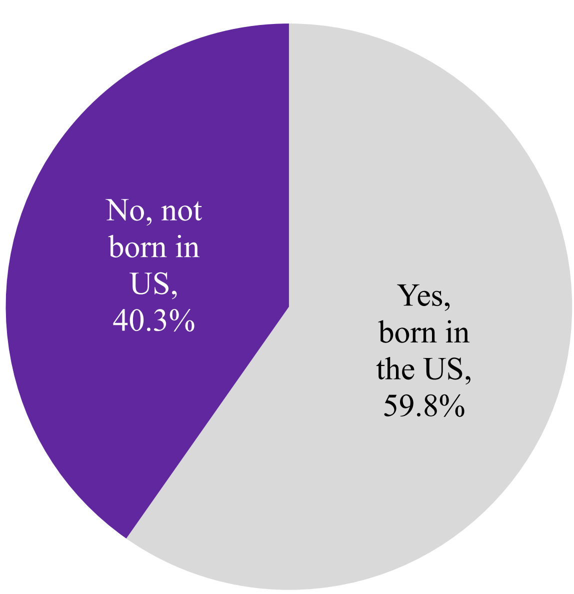
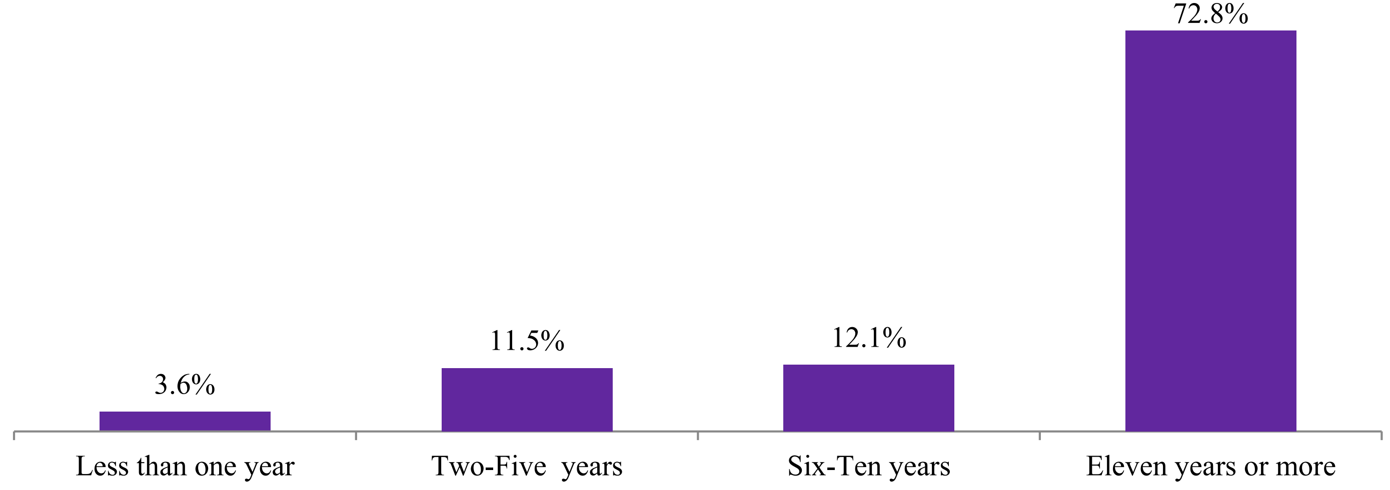



**Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]**




[31] Of those who were born outside of the U.S.

# Health Behaviors

**Exhibit 52. When members last saw a dentist (n=5,685)**

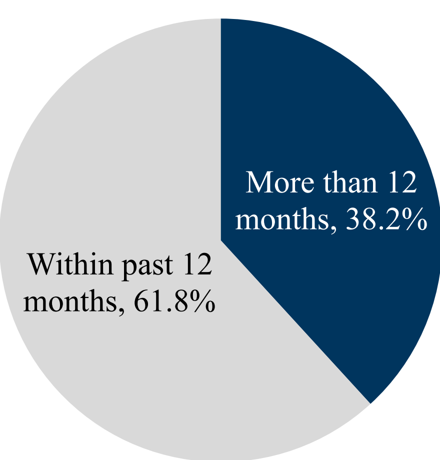
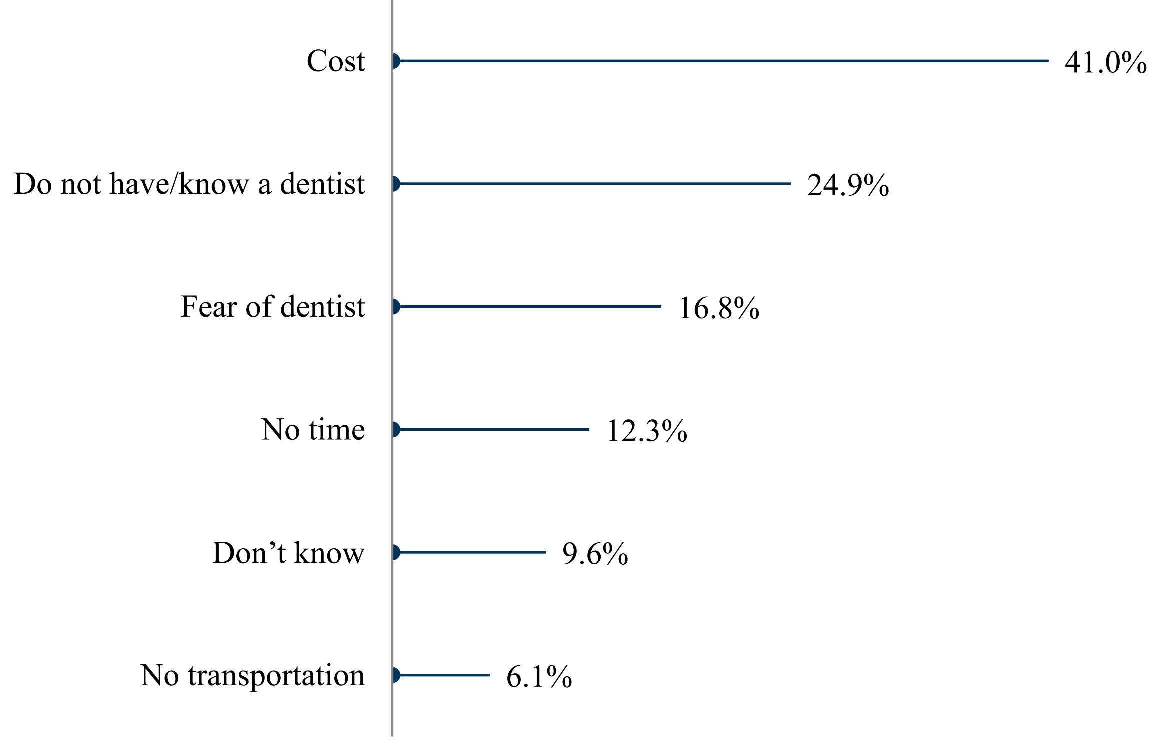


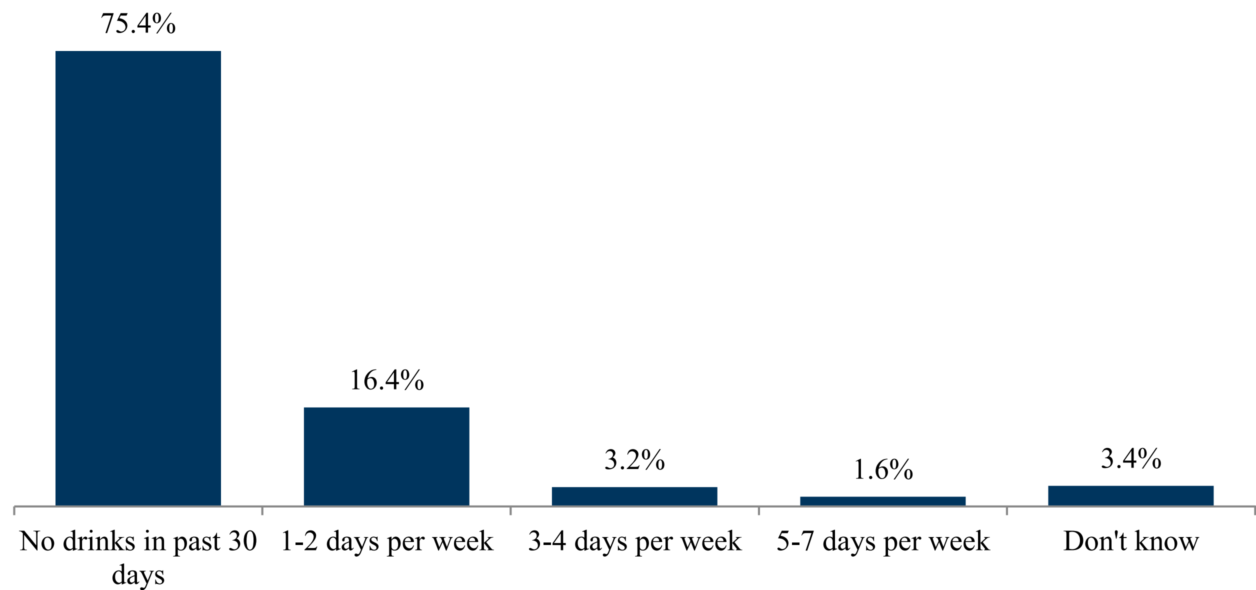

**Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]**




[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**

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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.

| # | 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.

**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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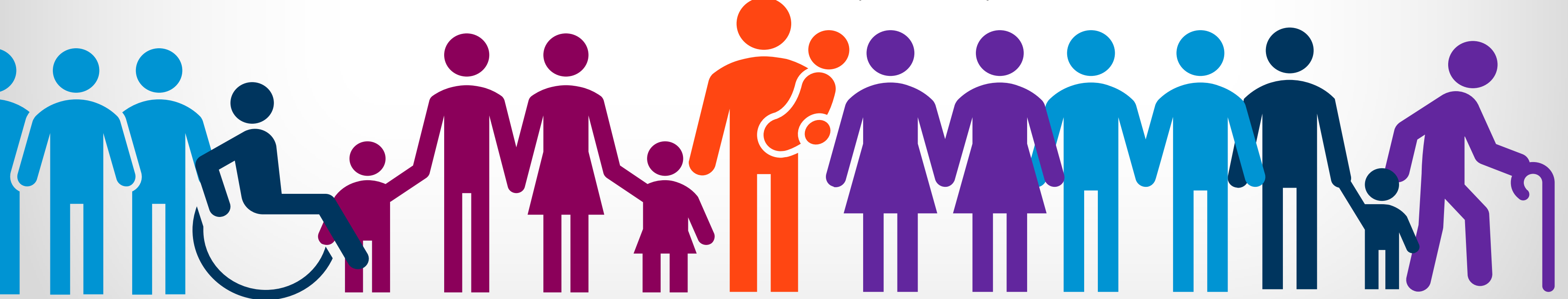
# More Comprehensive

- 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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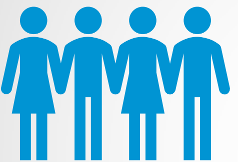
# More Engaging: Members



## 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

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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

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.

**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

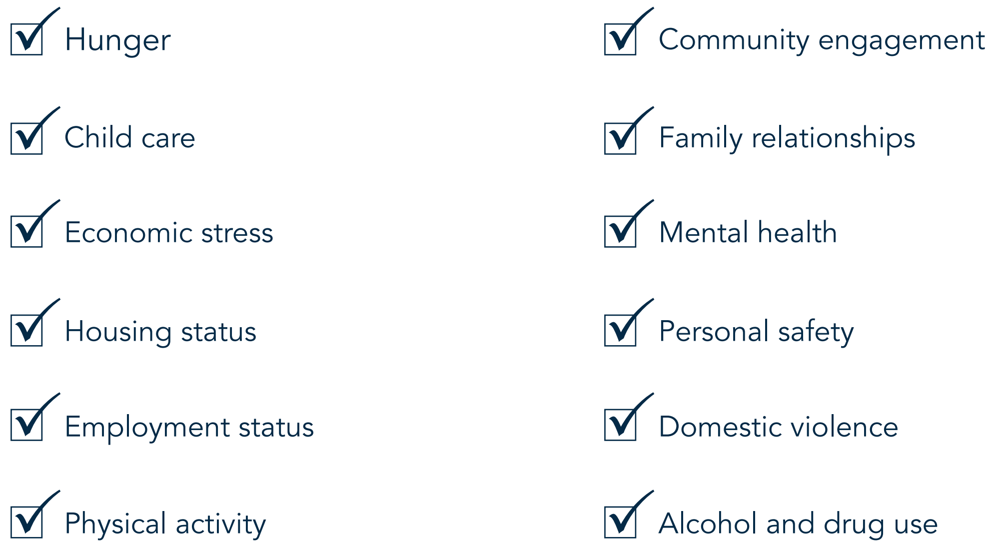
## More Comprehensive

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:




*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.

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## 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% |

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# 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)

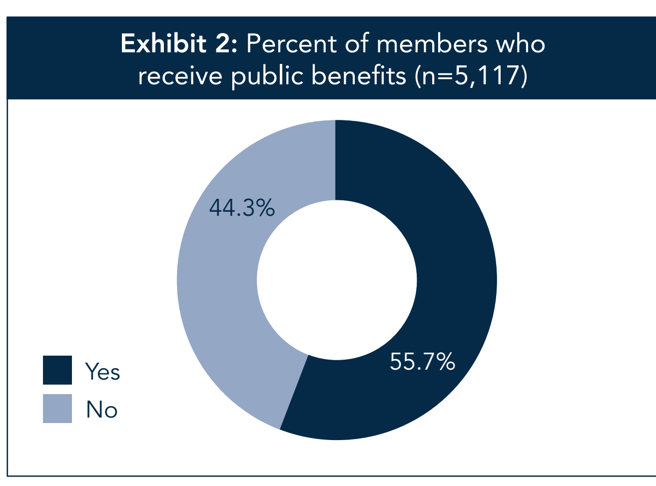
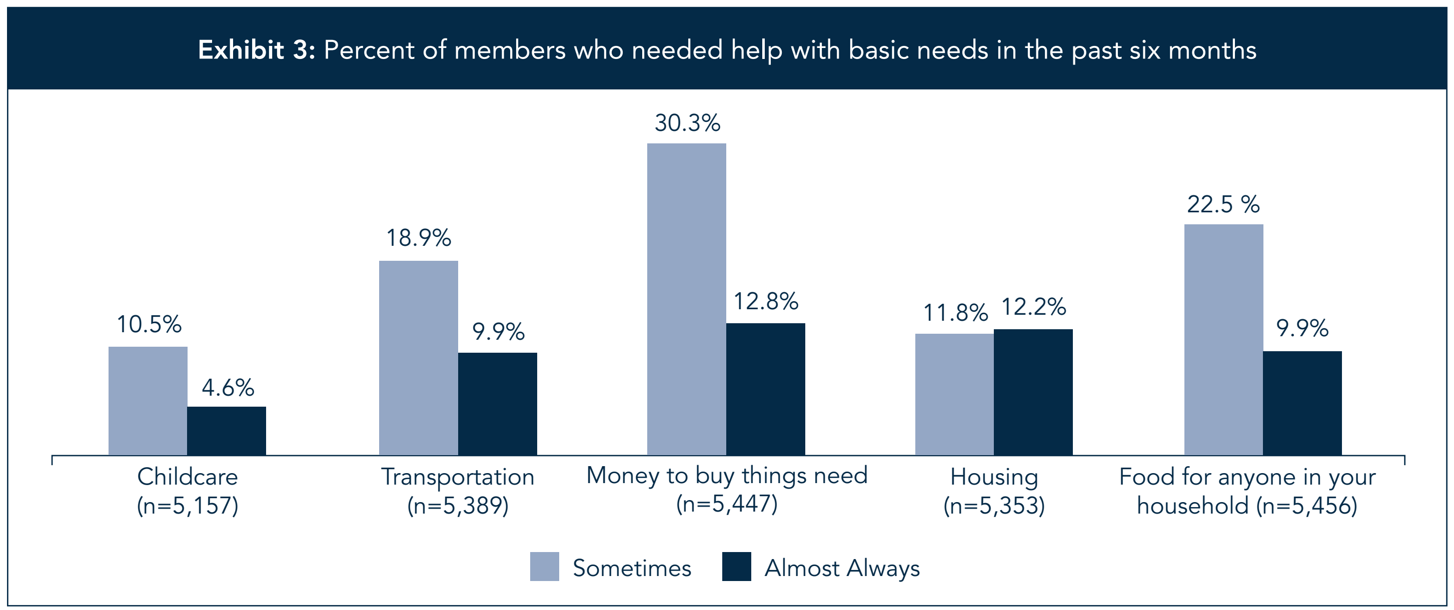
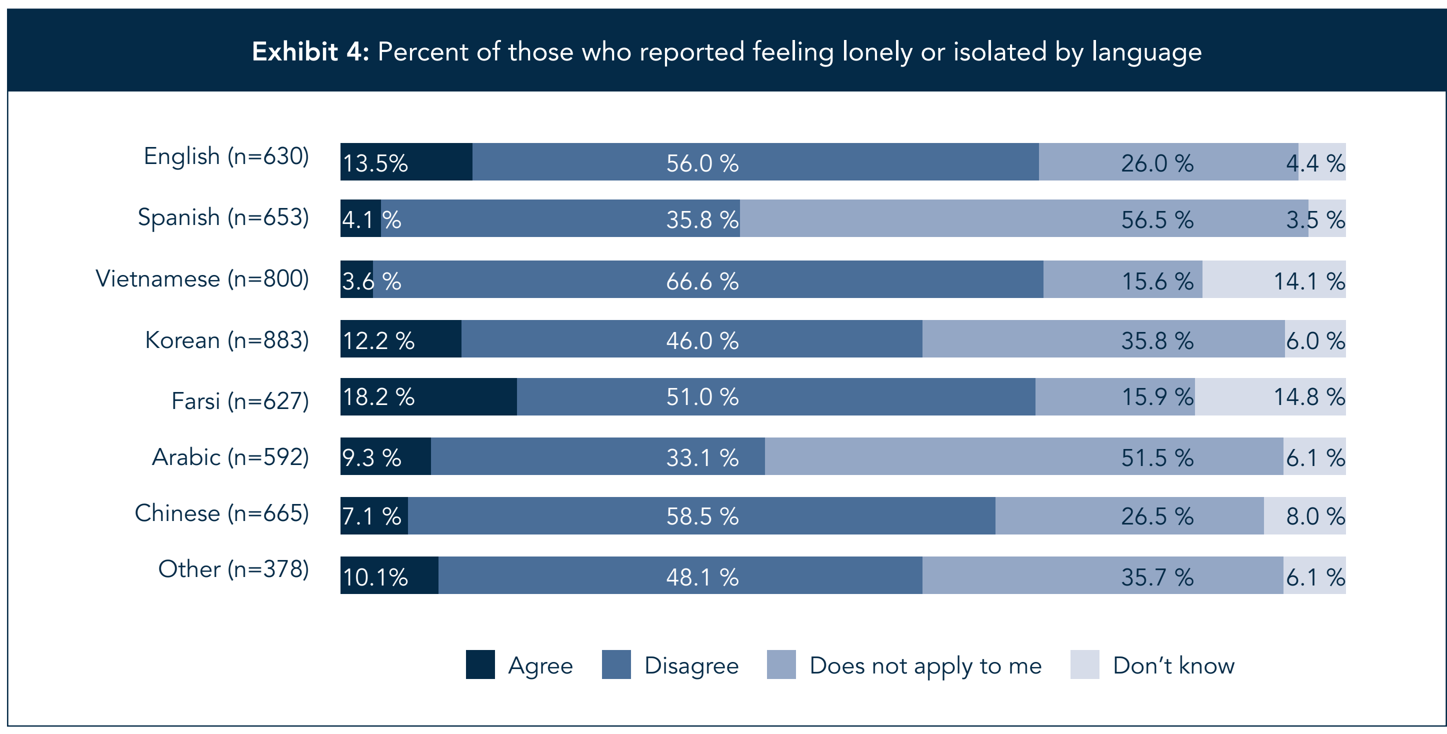



**Exhibit 3:** Percent of members who needed help with basic needs in the past six months



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.

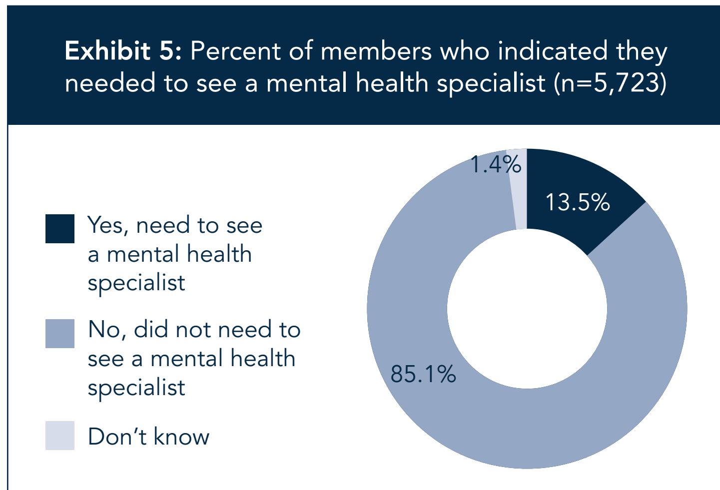
**Bright Spot:** CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health a priority, not a lack of knowledge or concern.

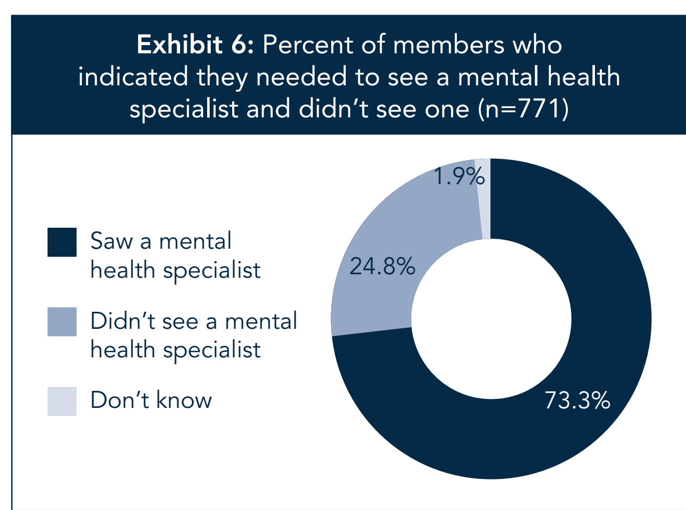
**Opportunity:** CalOptima has already taken steps to strengthen the safety net for members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand 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

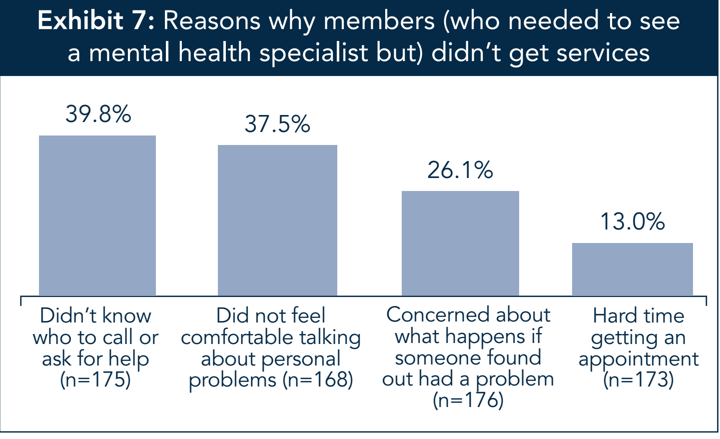
### *Lack of knowledge and fear of stigma are key barriers to using mental health services.*

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.




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.




**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)

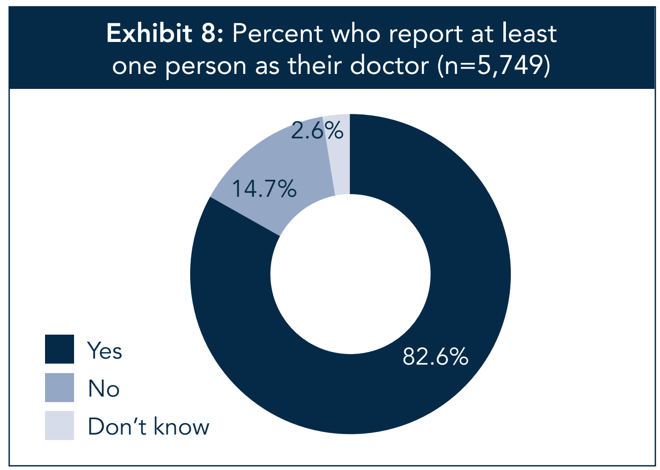
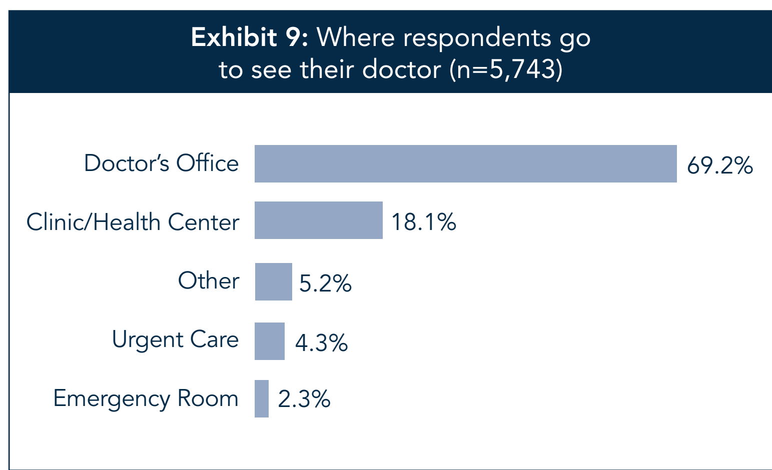



**Exhibit 9:** Where respondents go to see their doctor (n=5,743)

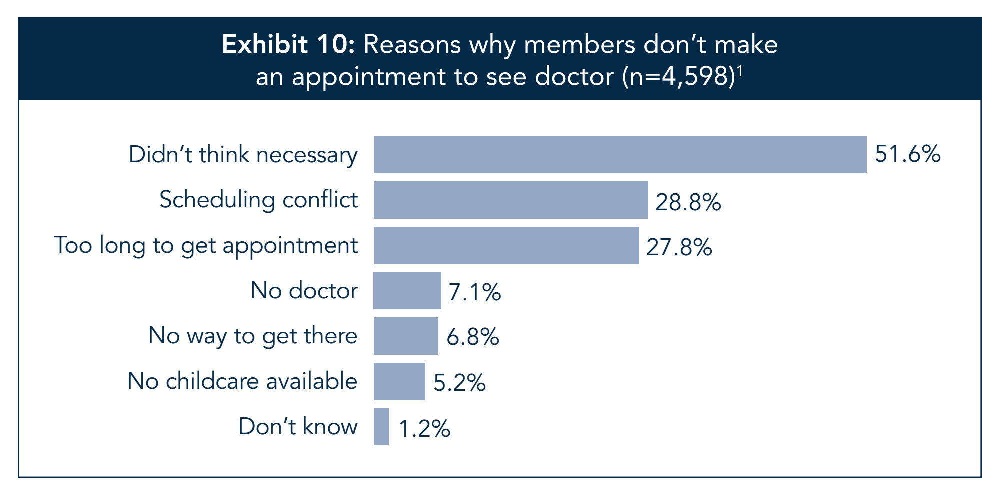



Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited 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)

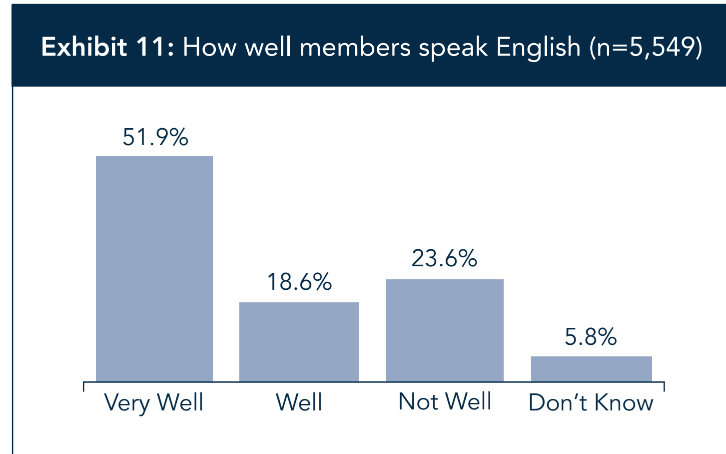
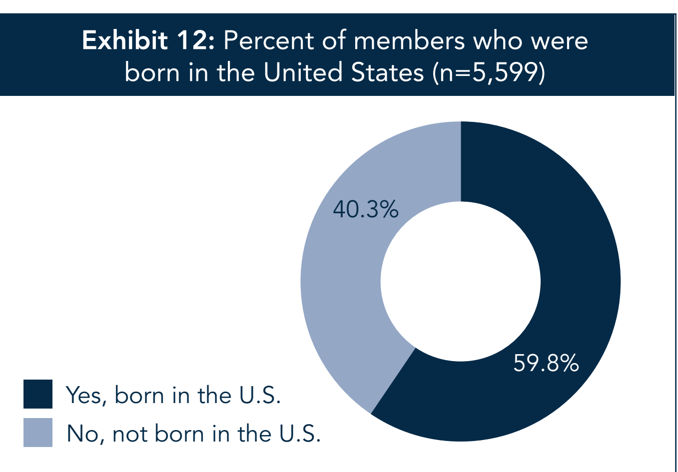



**Exhibit 12:** Percent of members who were born in the United States (n=5,599)




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.

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## 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)

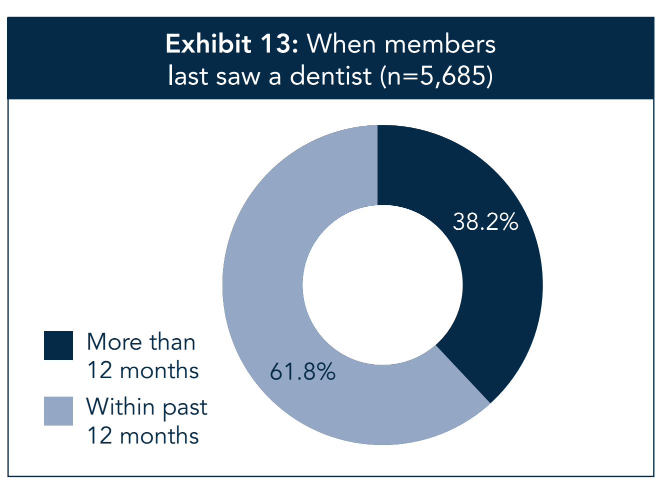
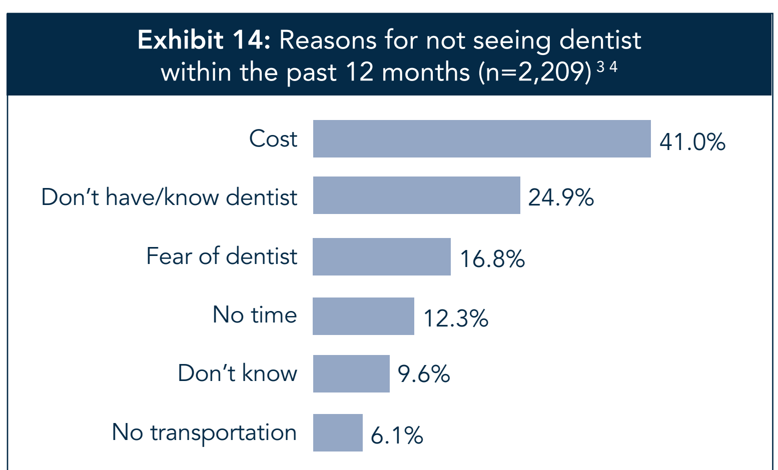



**Exhibit 14:** Reasons for not seeing dentist within the past 12 months (n=2,209)[3,4]




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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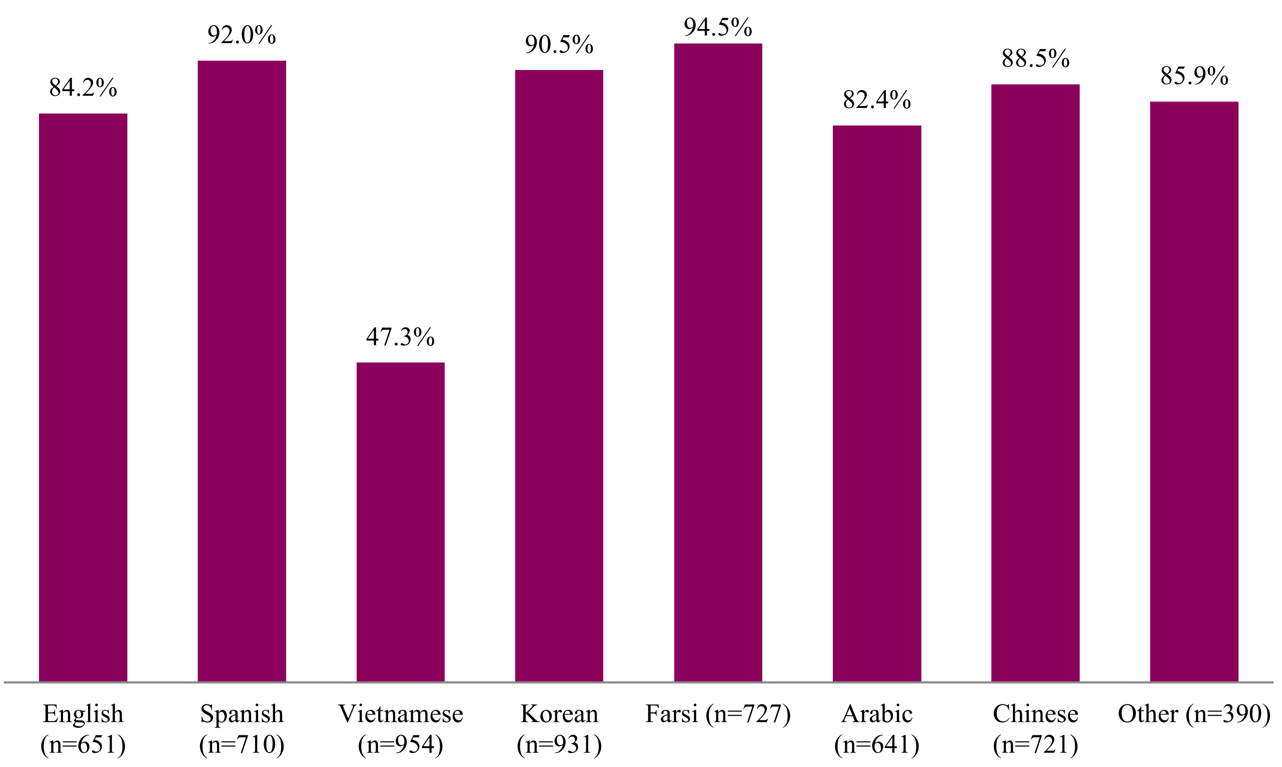
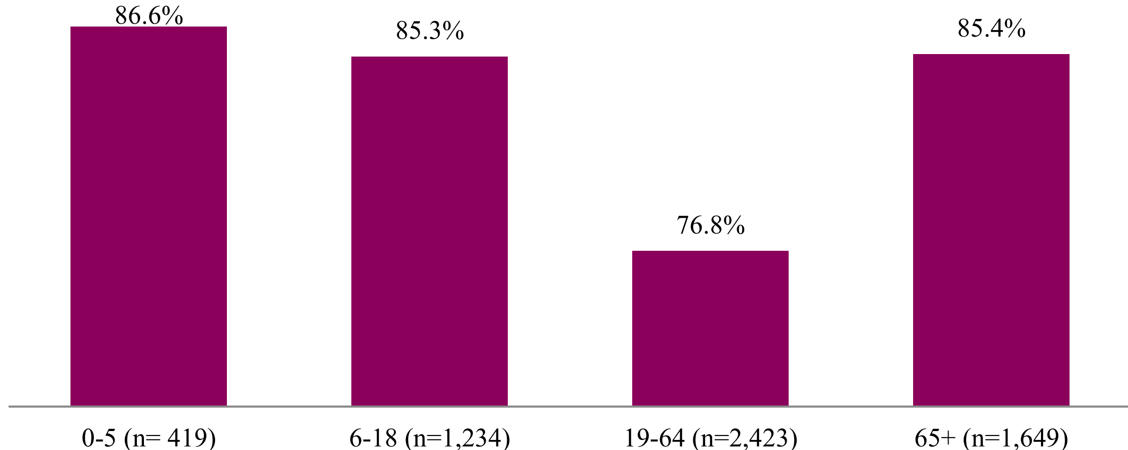
# Navigating the Healthcare System

**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:**

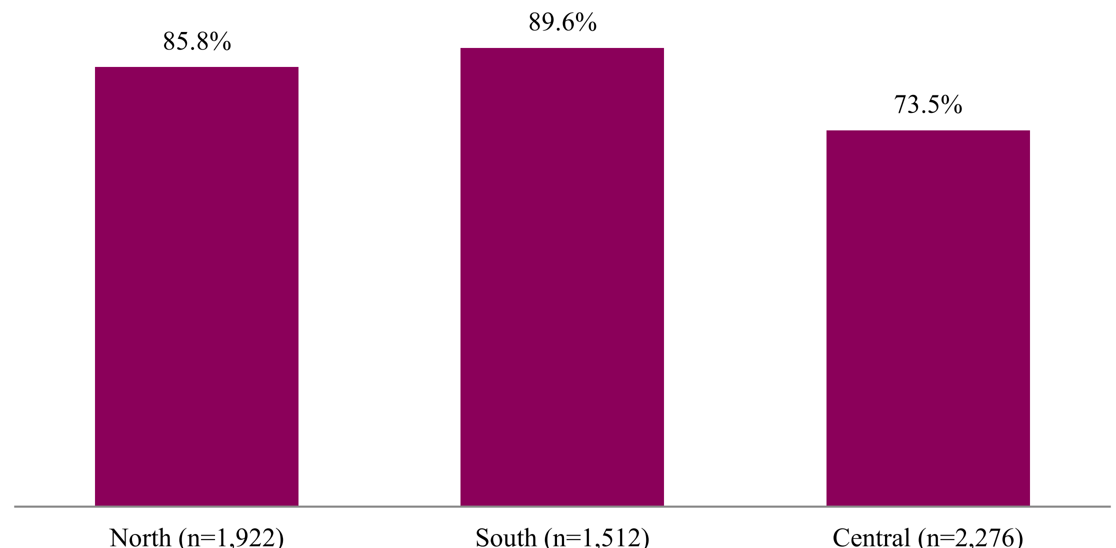


**Exhibit 2. Where respondents go to see their doctor**

**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<br>% | It is easier for me to get to the emergency room or urgent care than my doctor's office<br>% | It's hard to get an appointment with my doctor<br>% | Other<br>% | Don't know<br>% | 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 |



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**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<br>% | Check Up<br>% | Specialist Needed<br>% | Don't Know<br>% | Other<br>% | 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<br>% | Doctor helped schedule the appointment<br>% | Important for health<br>% | 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<br>% | Doctor helped schedule the appointment<br>% | Important for health<br>% | 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<br>% | Doctor helped schedule the appointment<br>% | Important for health<br>% | 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<br>% | No transportation<br>% | Appointments not at times that work with schedule<br>% | Takes too long to get an appointment<br>% | Didn't think needed to go<br>% | 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<br>% | No transportation<br>% | Appointments not at times that work with schedule<br>% | Takes too long to get an appointment<br>% | Didn't think needed to go<br>% | 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 |

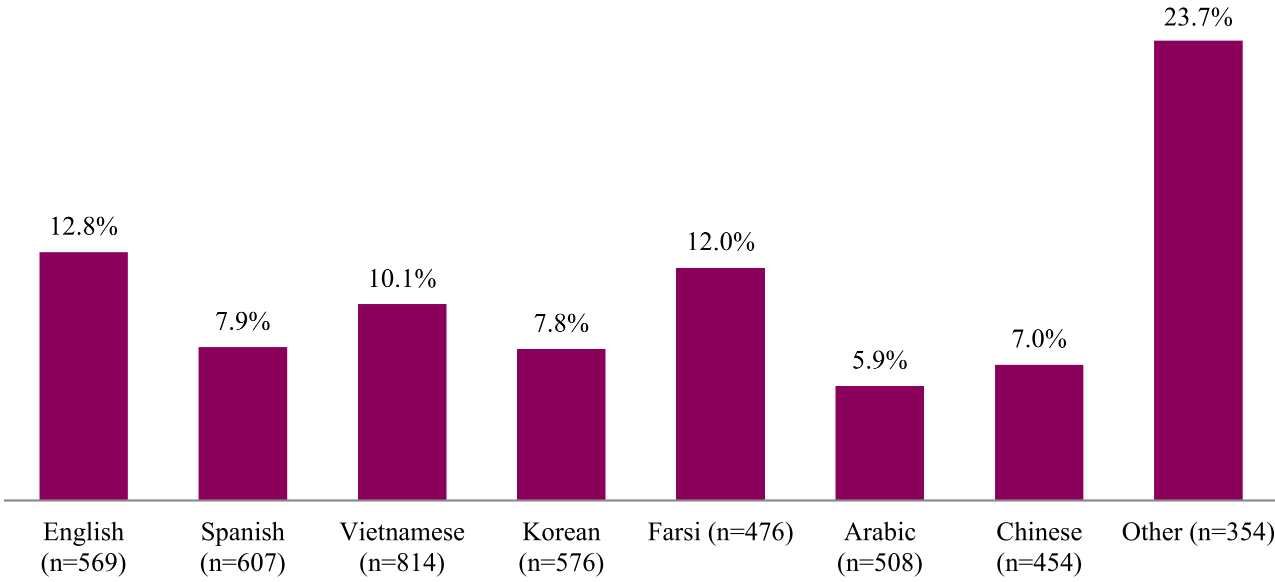
[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

**Region:**

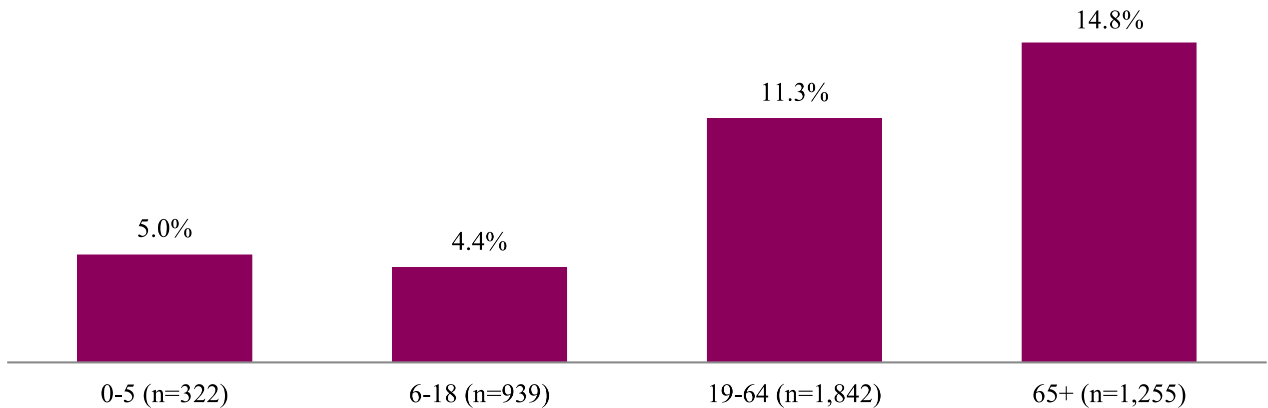
| Region | Too far away<br>% | No transportation<br>% | Appointments not at times that work with schedule<br>% | Takes too long to get an appointment<br>% | Didn't think needed to go<br>% | n |
|---|---|---|---|---|---|---|
| **North** | 14.0% | 11.3% | 24.8% | 35.9% | 31.1% | 1,567 |
| **South** | 13..6% | 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**

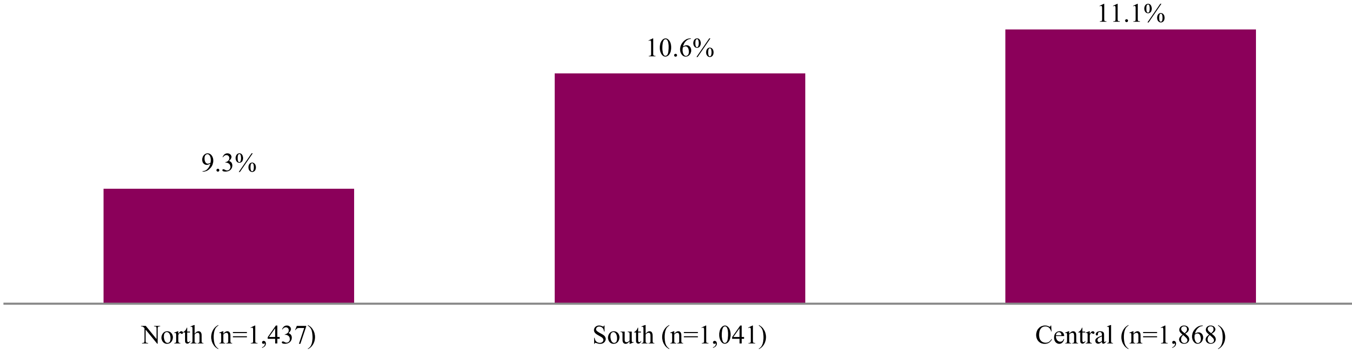
**CalOptima language:**




**Age Category:**




**Region:**



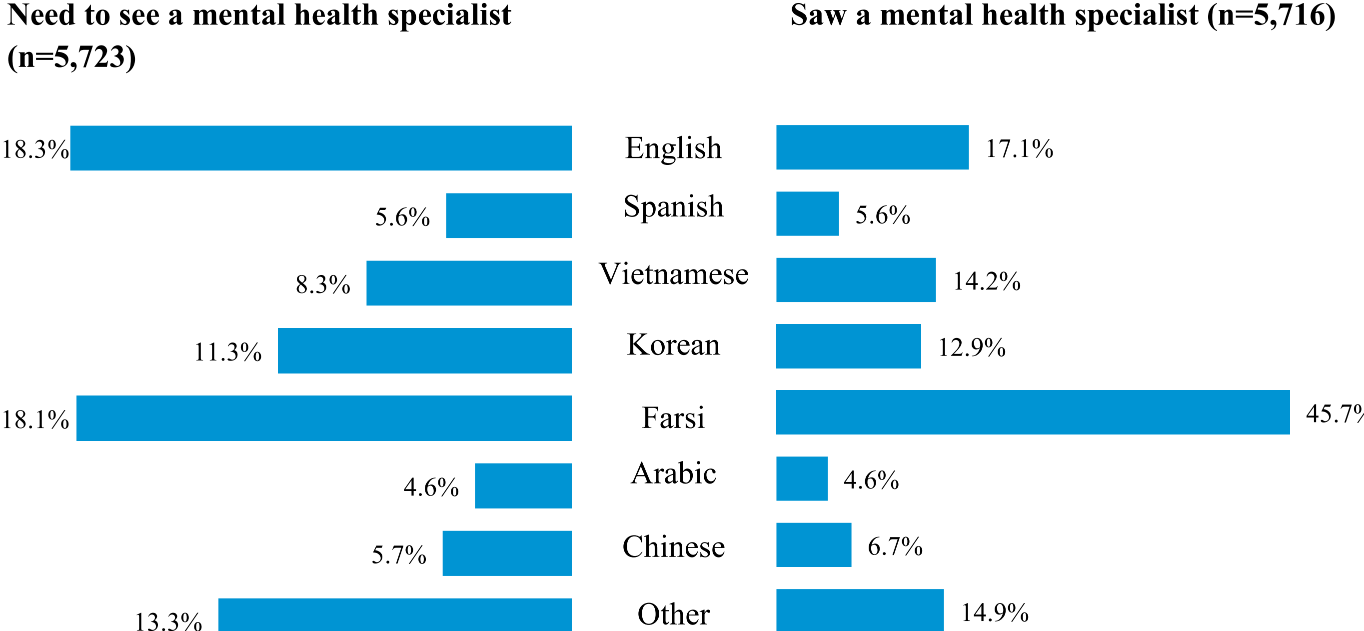
# Social and Emotional Well-Being

**Exhibit 9. Members who needed to see compared to those who saw a mental health specialist in the last 12 months**[6]

**CalOptima Language:**

**Need to see a mental health specialist (n=5,723)**

**Saw a mental health specialist (n=5,716)**

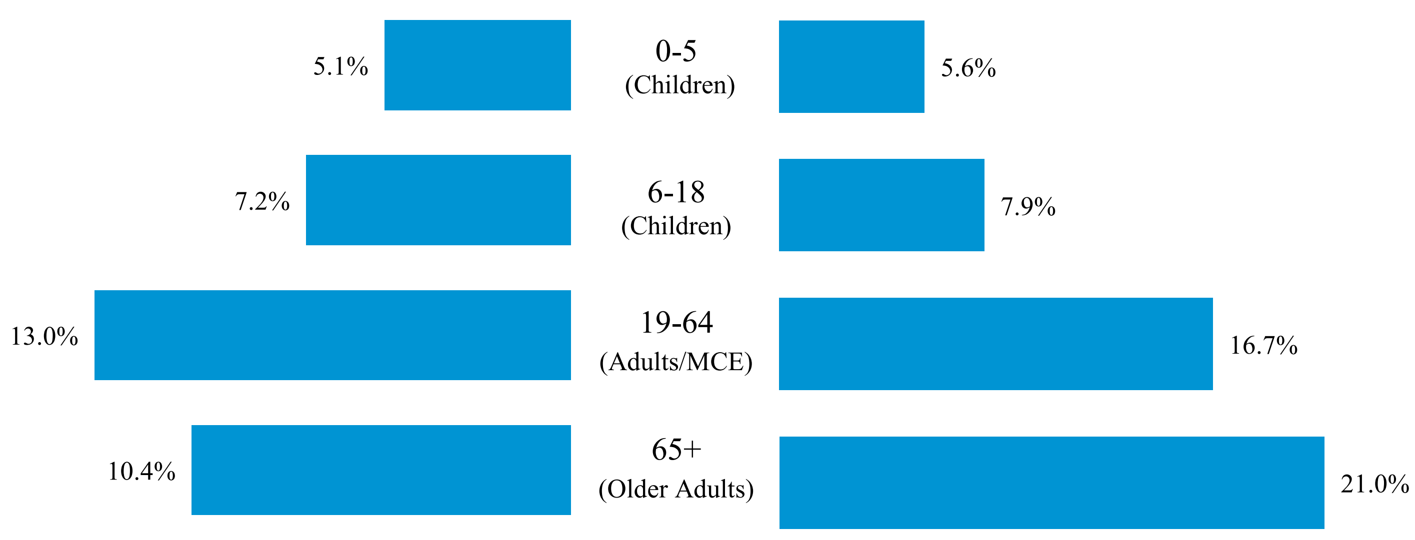



[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

**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)**

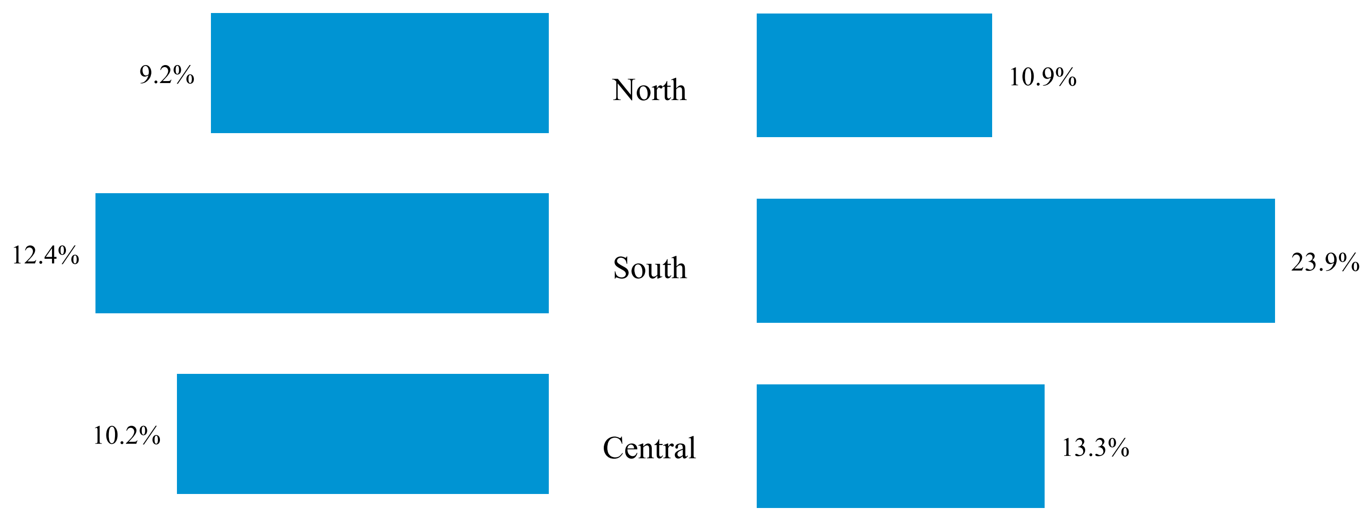
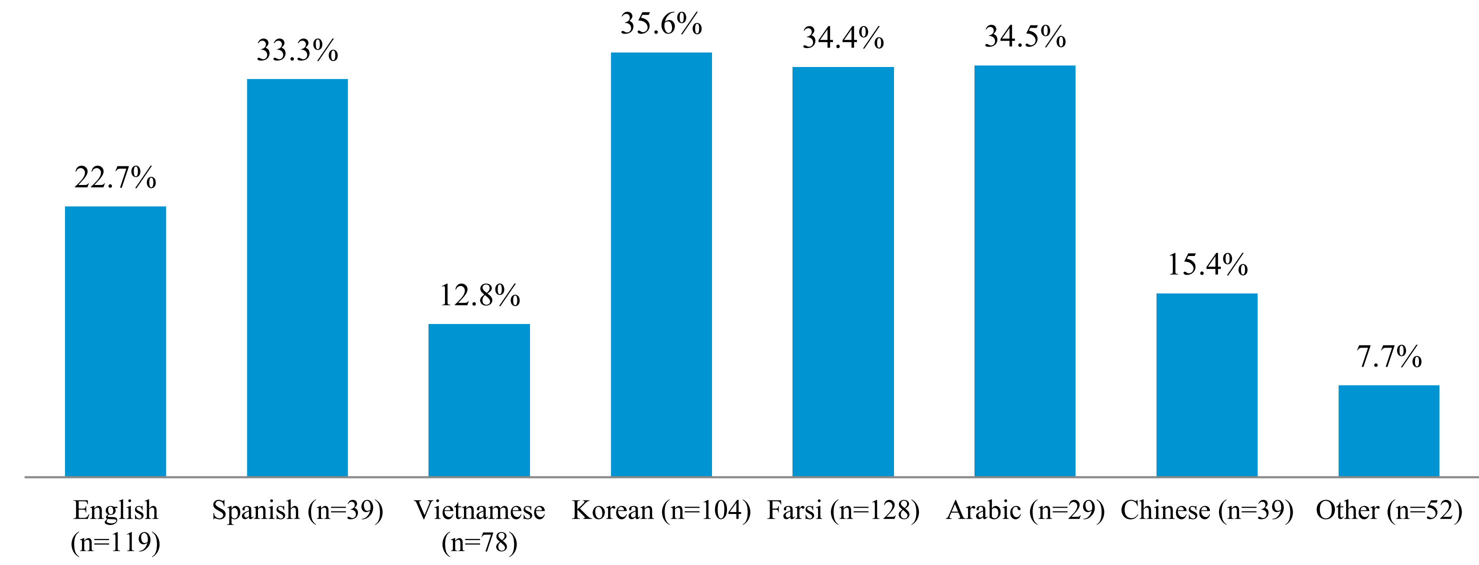
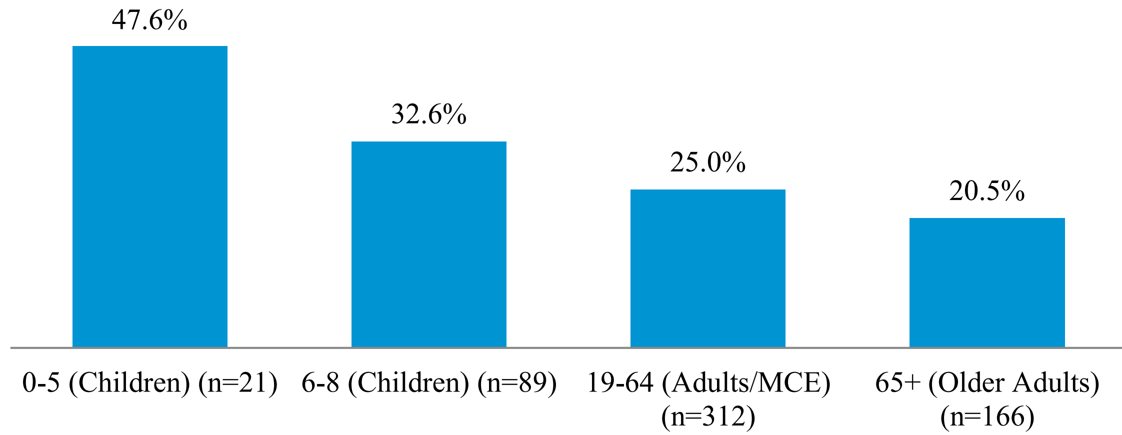


**Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist**

**CalOptima Language:**




**Age Category:**




**Region:**

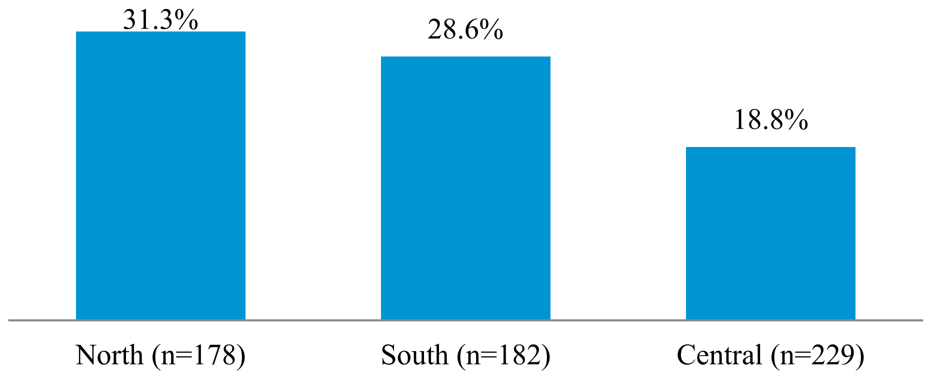
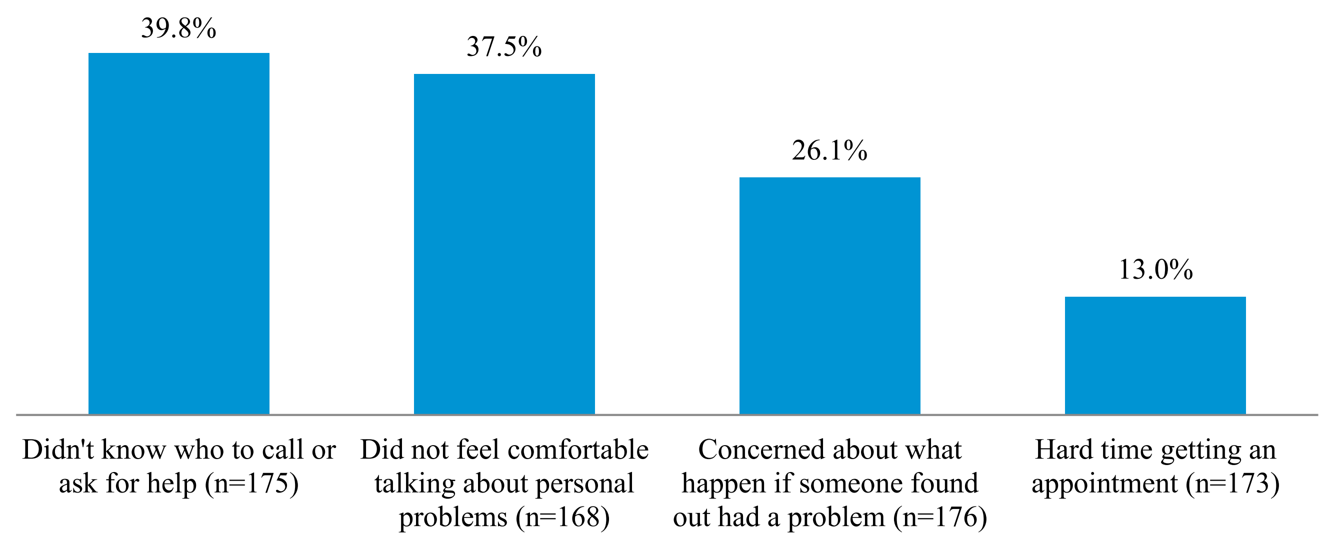


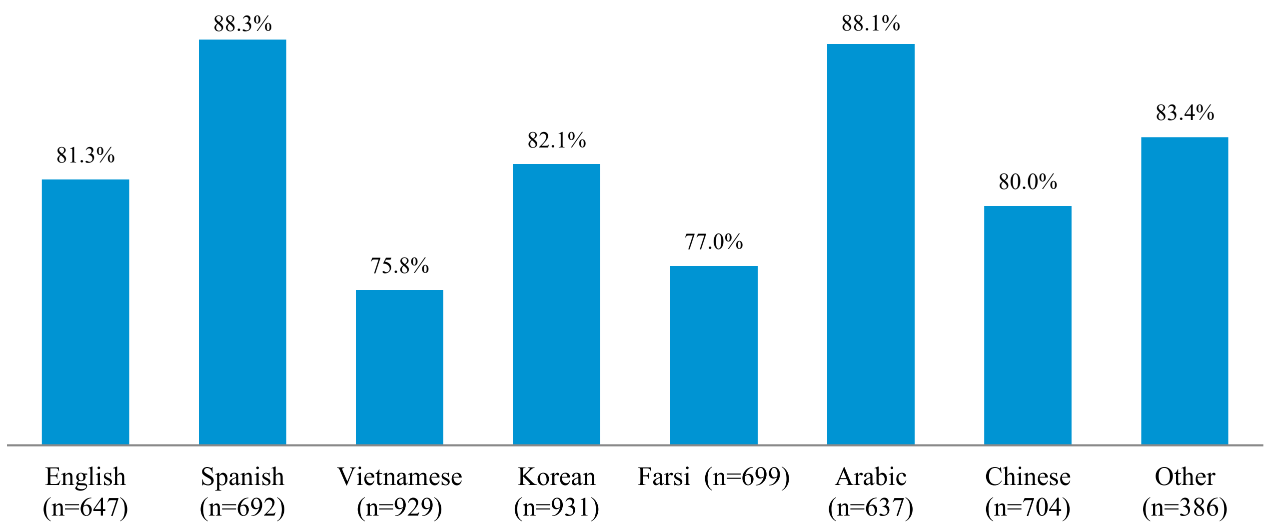
**Exhibit 11. Reasons why members didn't see mental health specialist**[7]



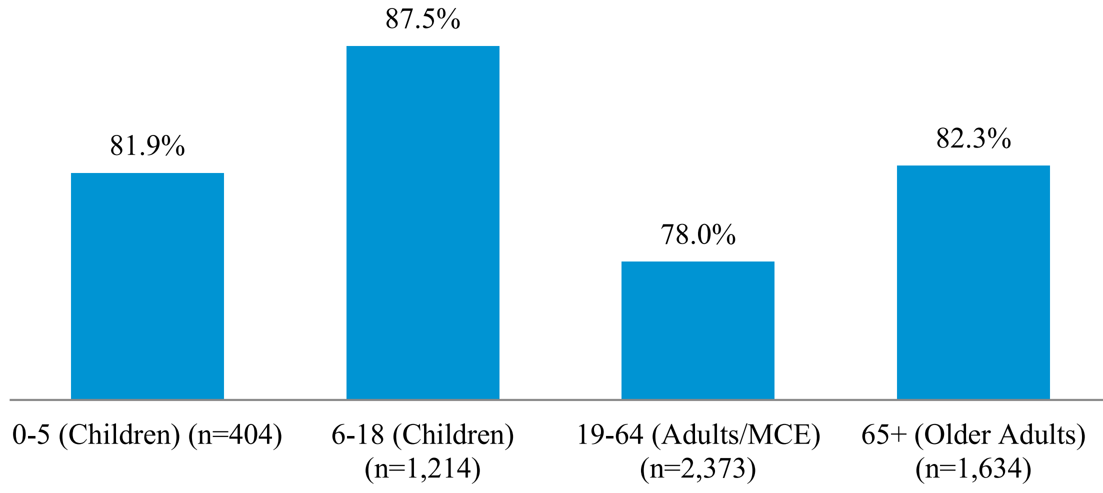

[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

**Exhibit 12. Percent of members who can share their worries with family members**

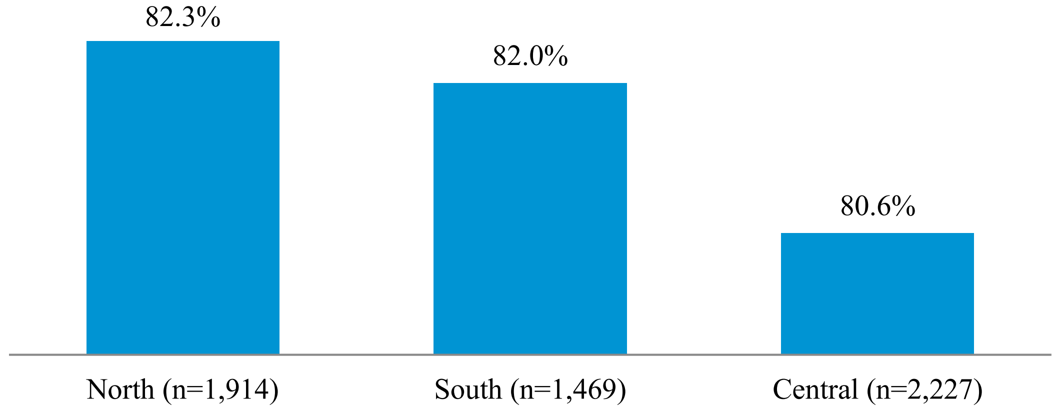
**CalOptima language:**




**Age Category:**




**Region:**

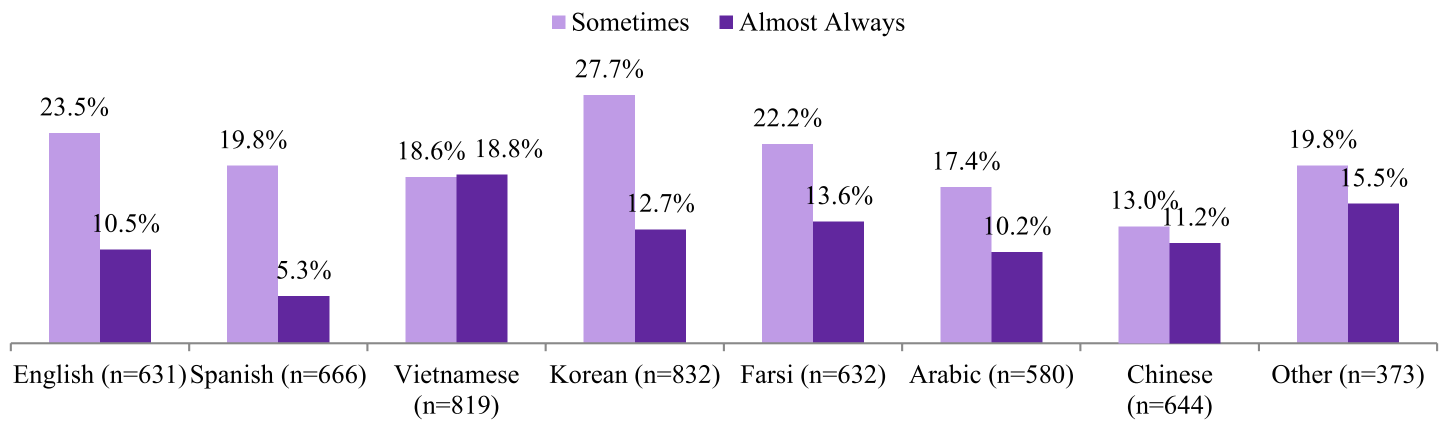


# Social Determinants of Health

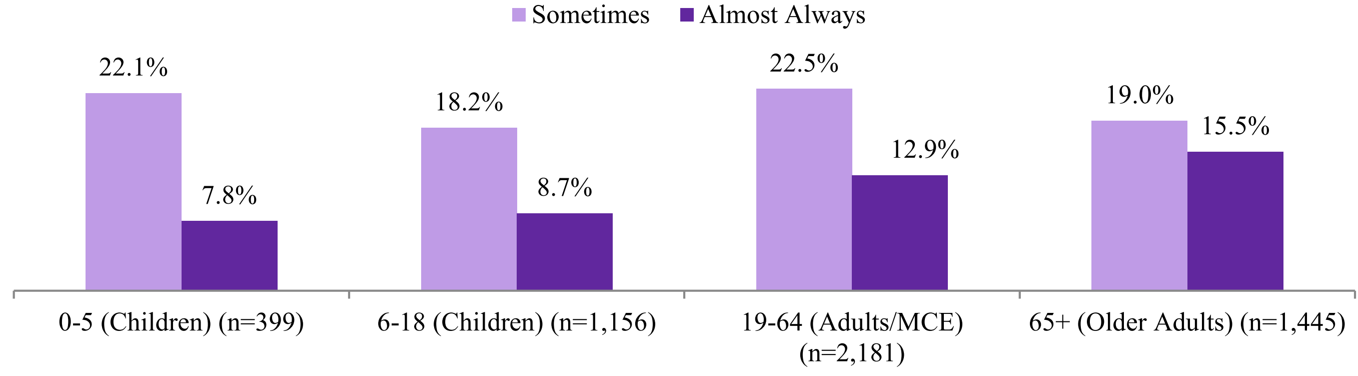
**Exhibit 13. Needed help with the following in the past 6 months:**

**Food for anyone in your household:**

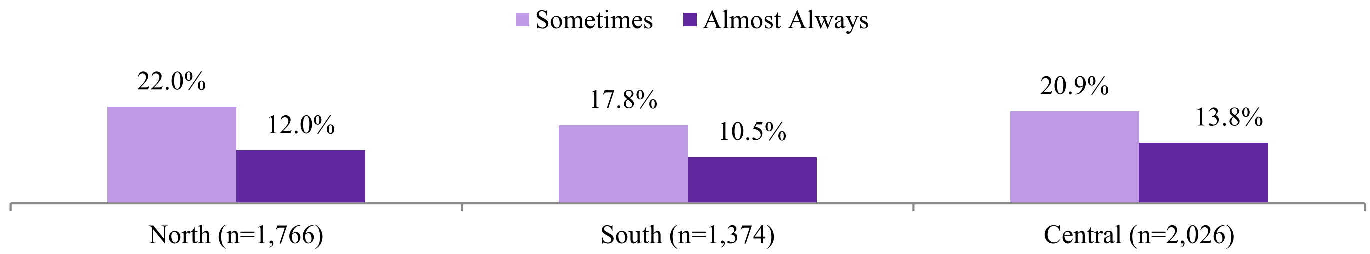
**CalOptima language:**




**Age Category:**

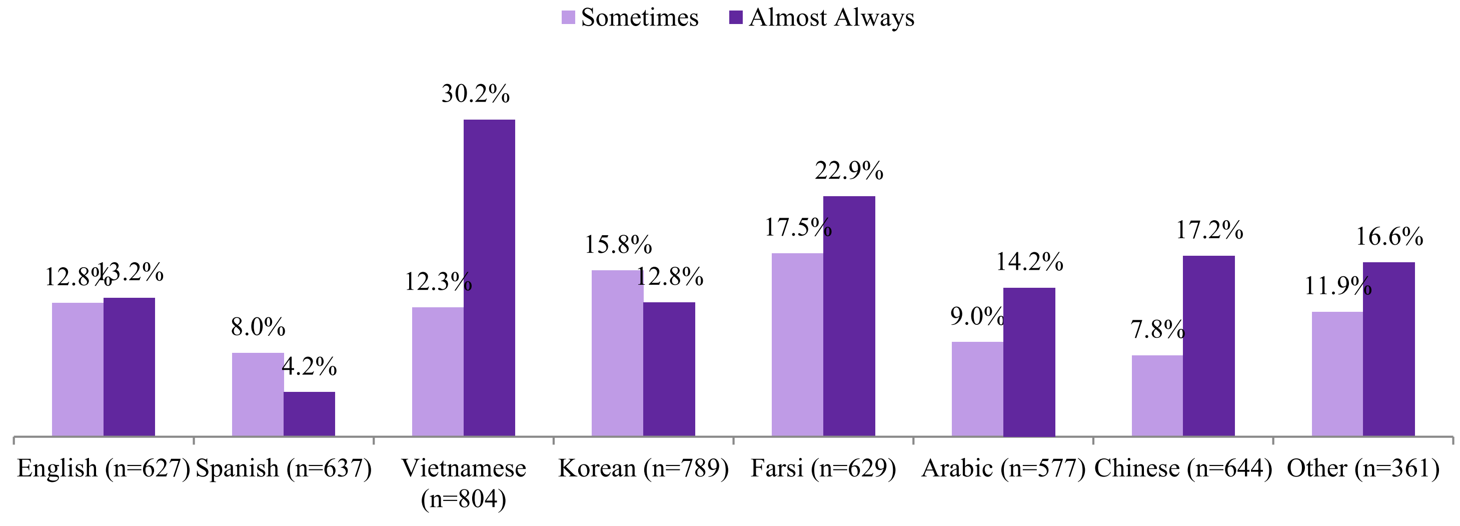



**Region:**

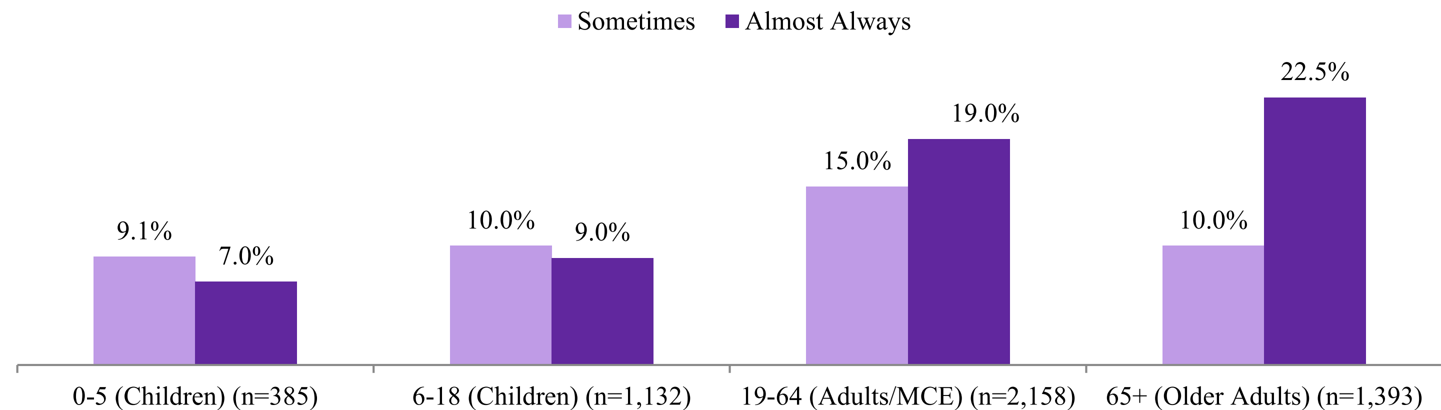


**Housing:**

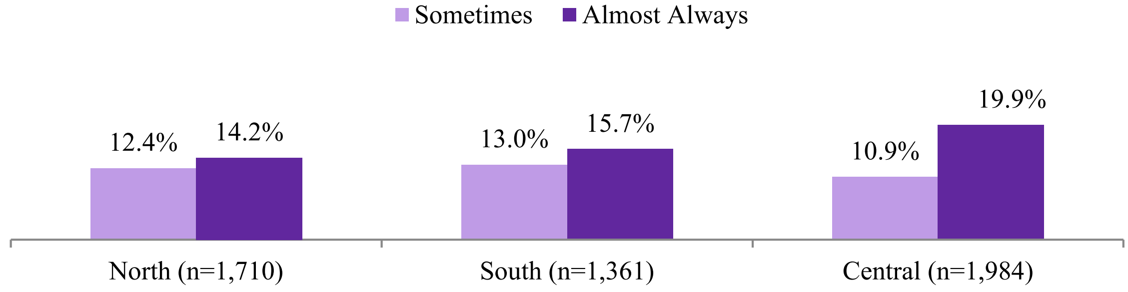
**CalOptima language:**




**Age Category:**

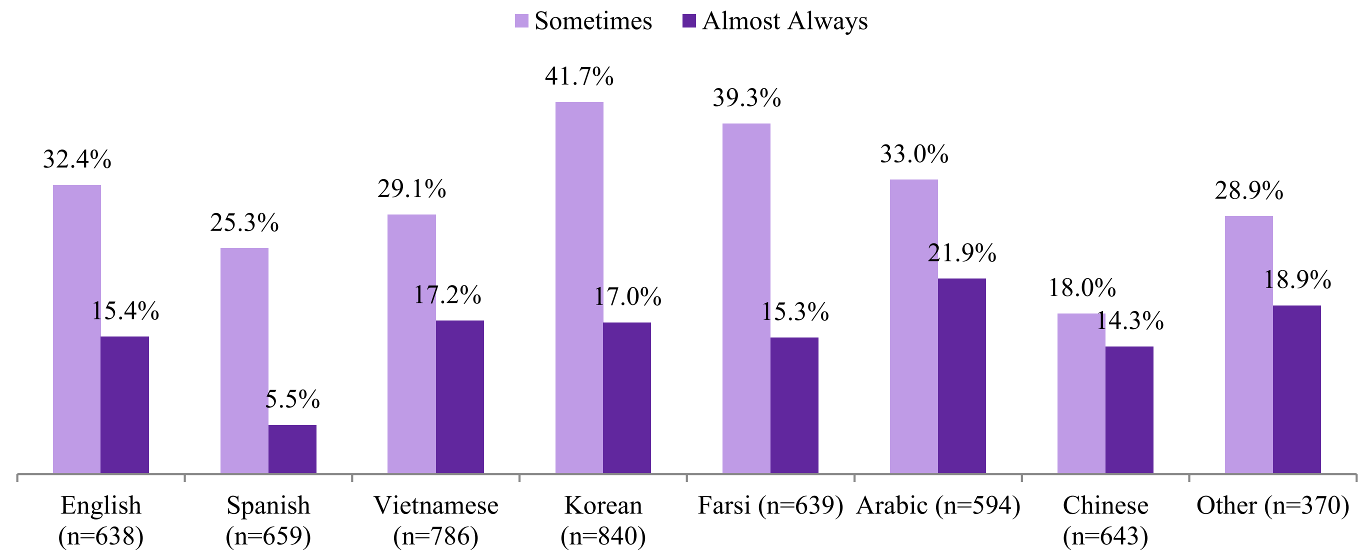



**Region:**

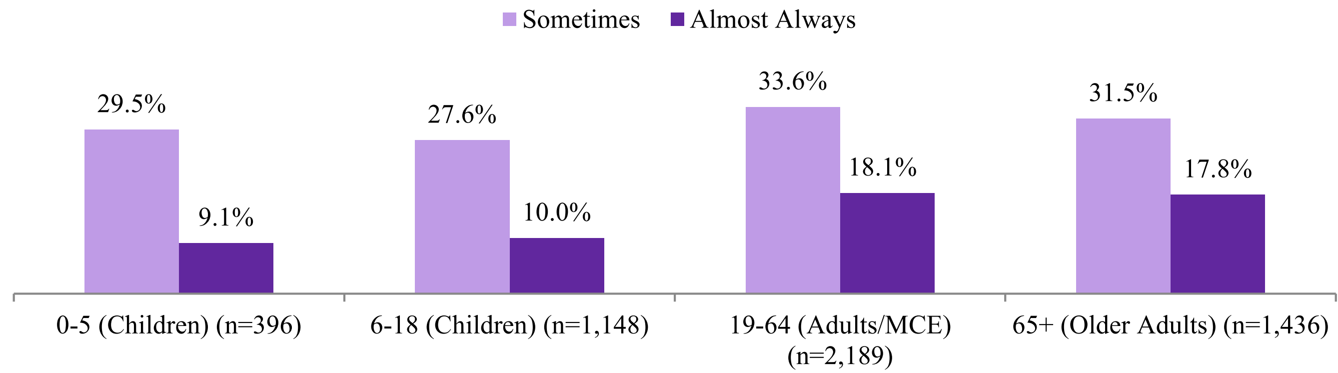


**Money to buy things need:**

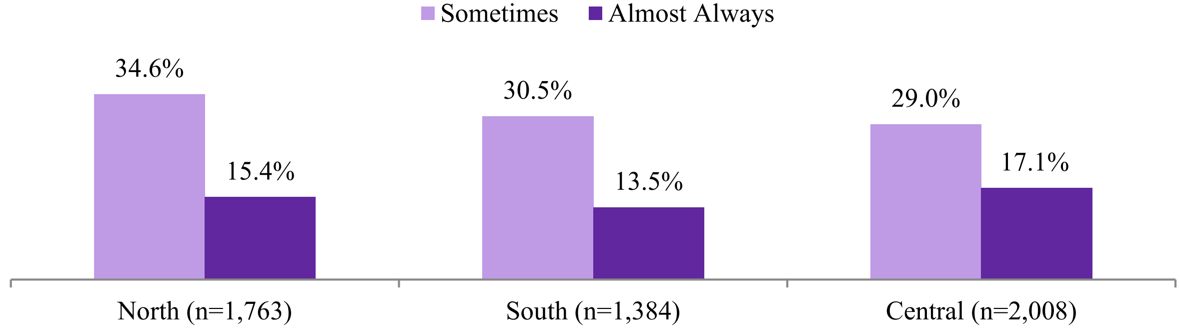
**CalOptima language:**




**Age Category:**

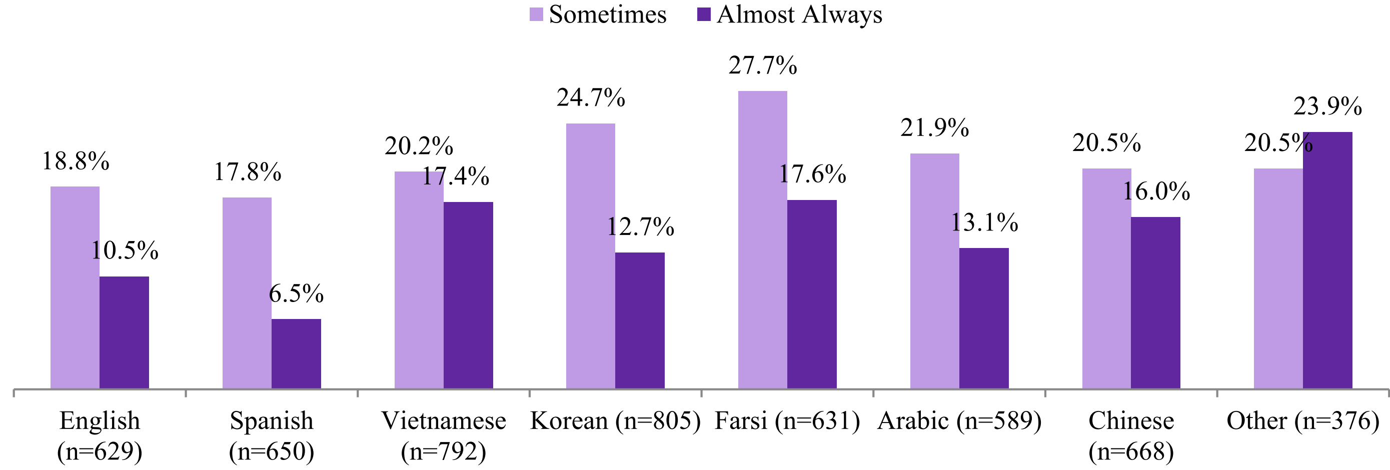



**Region:**

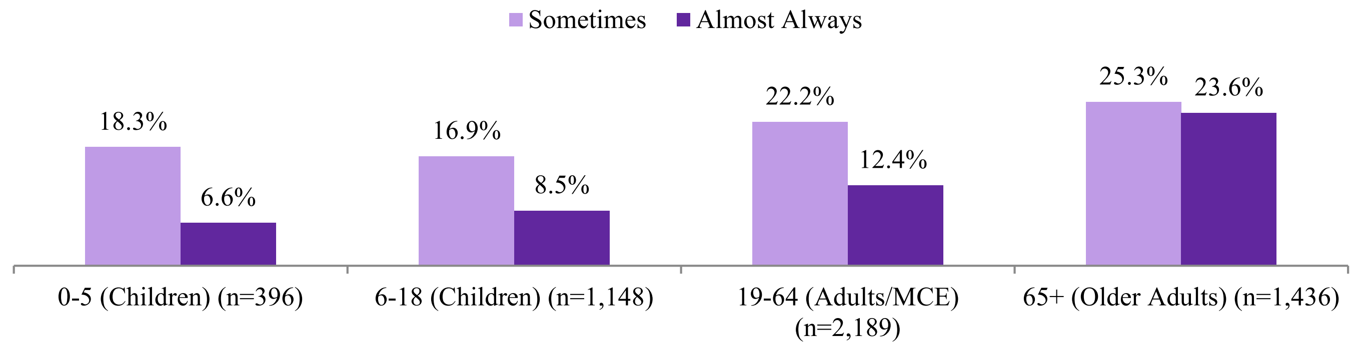


**Transportation:**

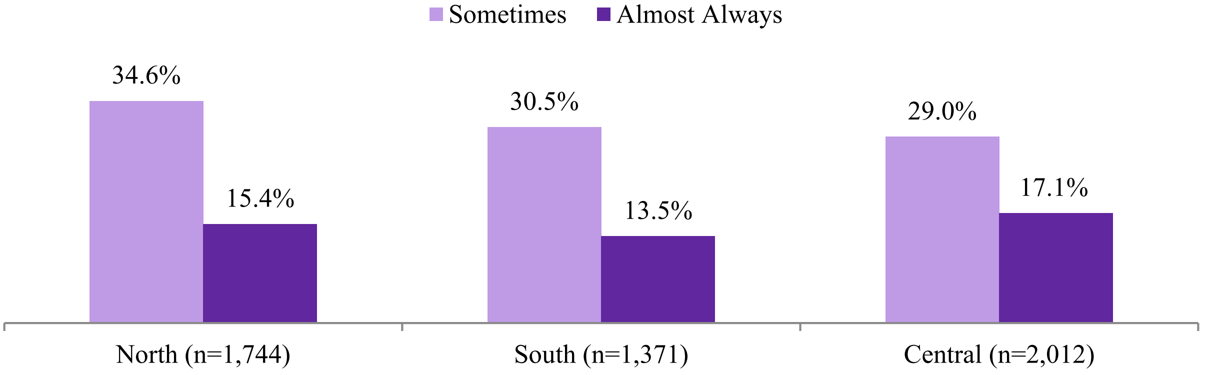
**CalOptima language:**




**Age Category:**

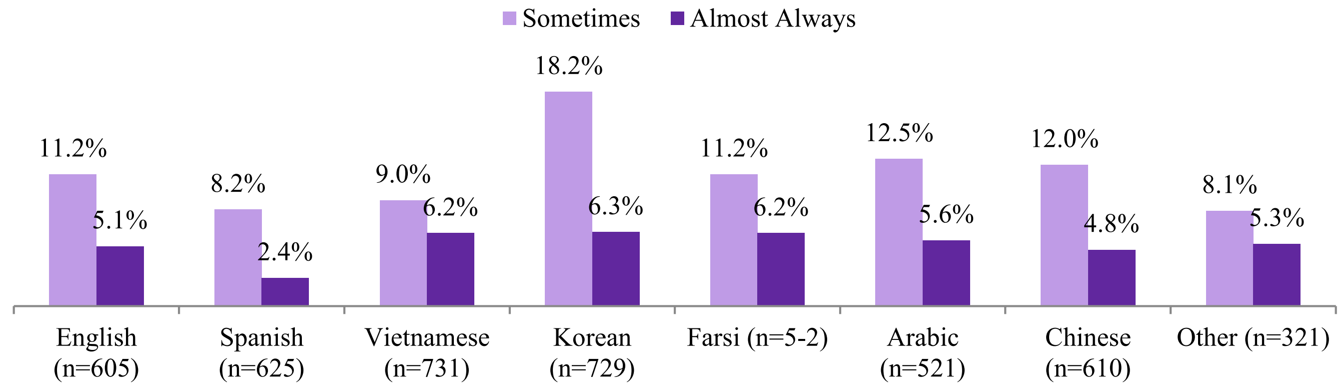



**Region:**

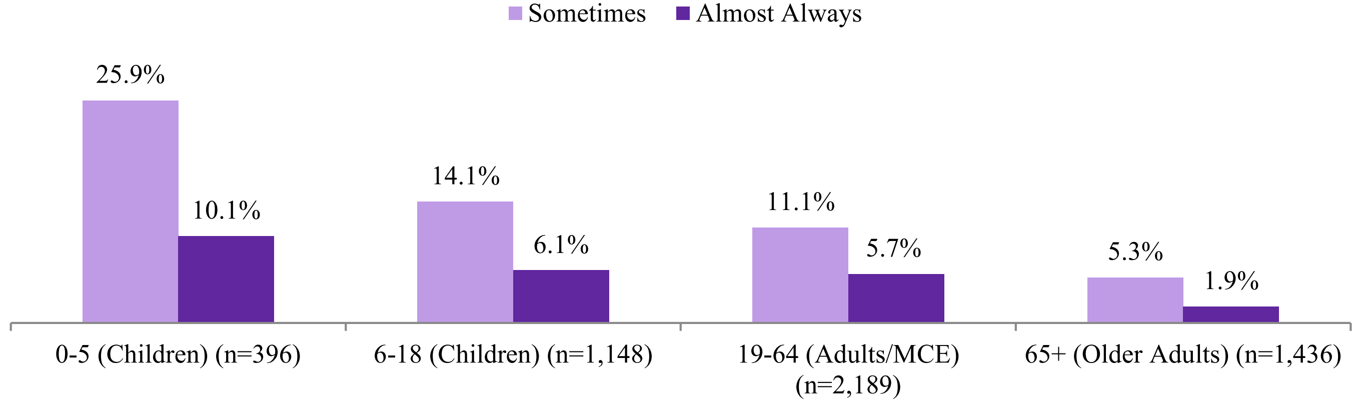


**Child care:**

**CalOptima language:**




**Age Category:**




**Region:**

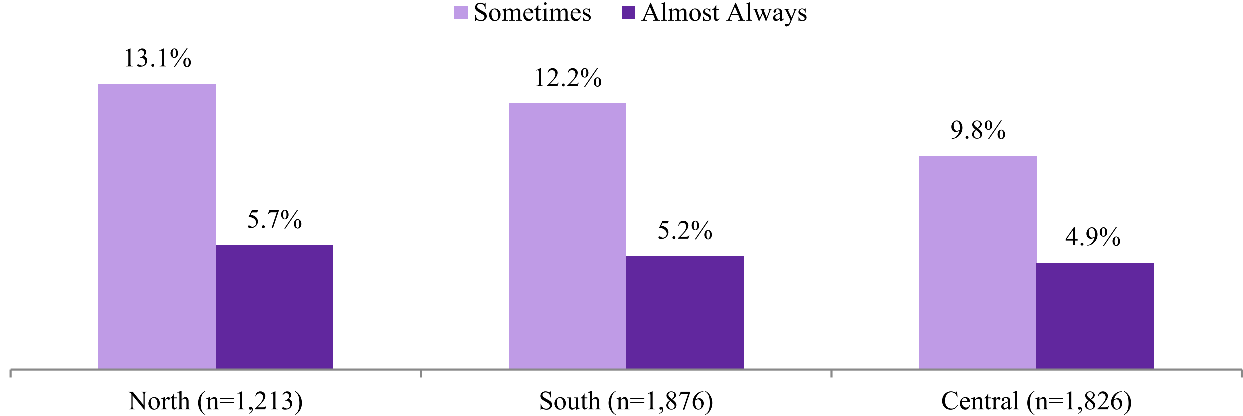
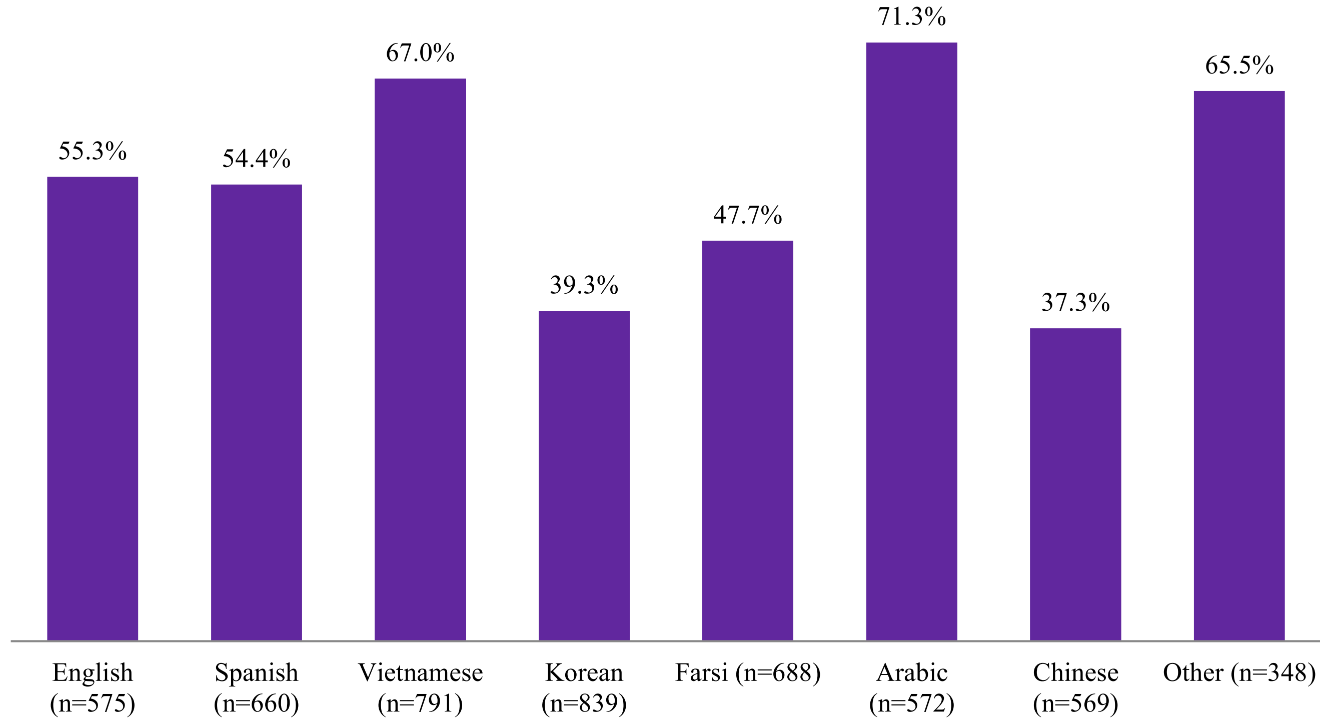


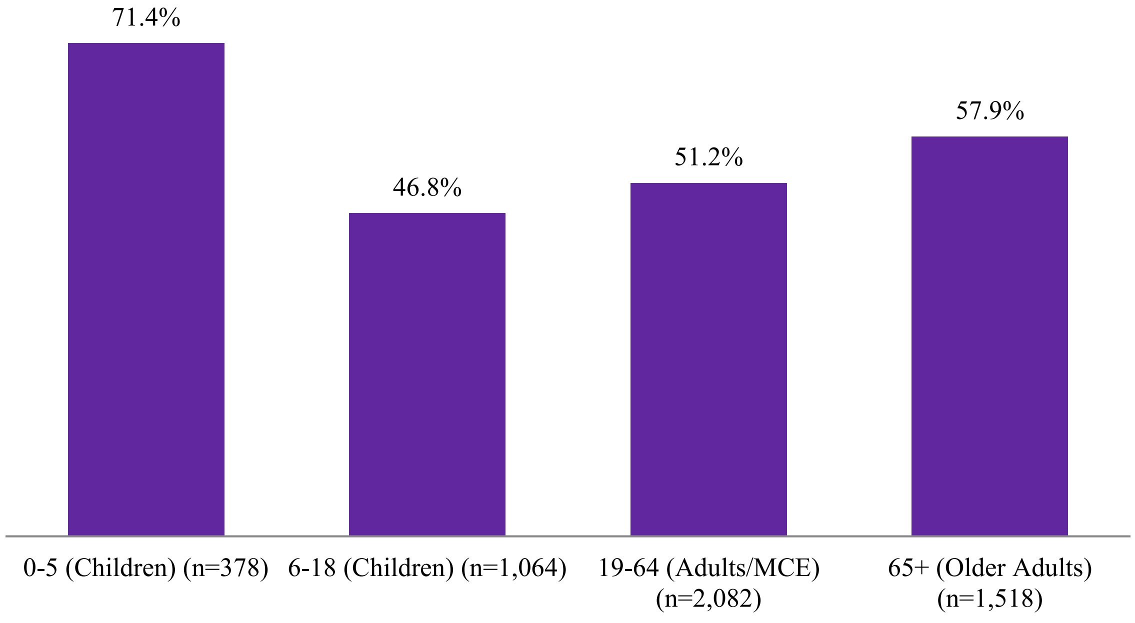
**Exhibit 14. Members who received public benefits**

**Percent of members who receive public benefits:**

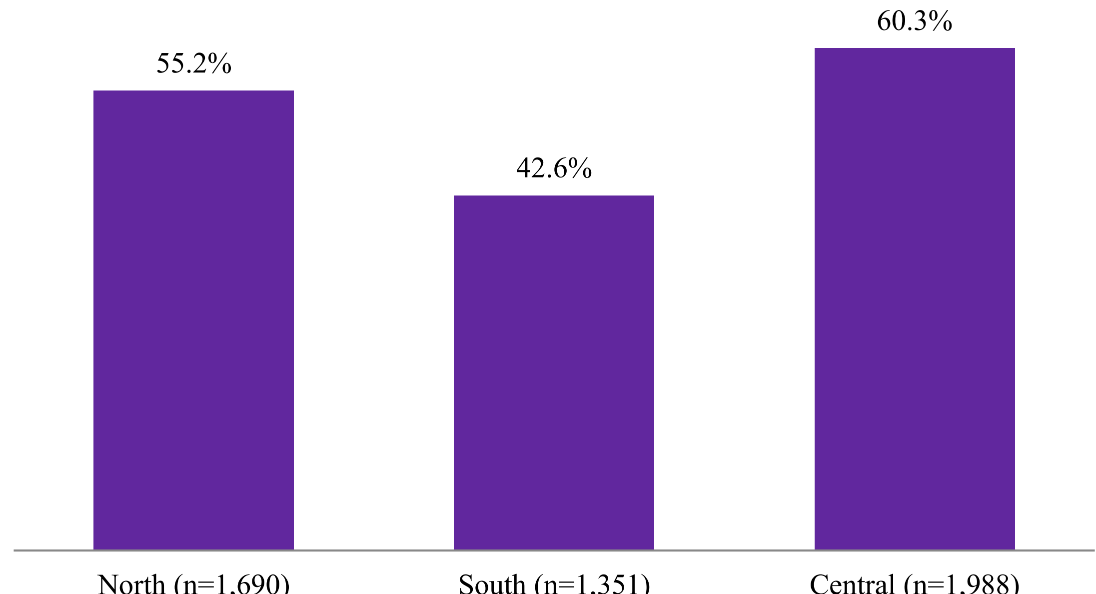
**CalOptima language:**




**Age Category:**



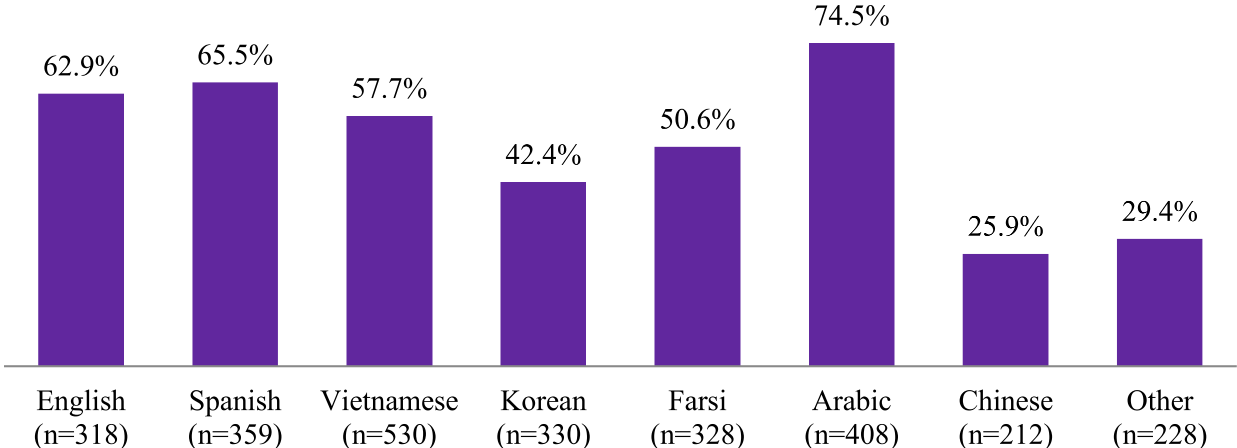
**Region:**



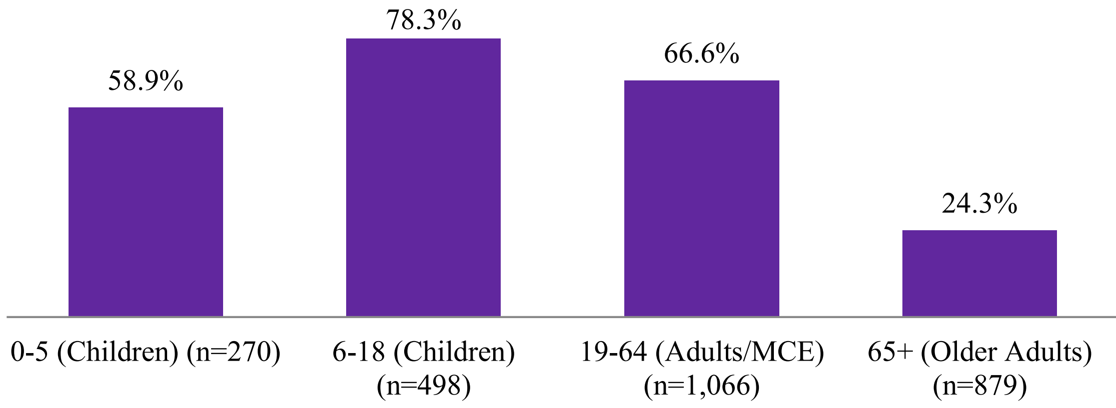
**Type of public benefits that members receive[8]:**

**Receive CalFresh as a public benefit:**

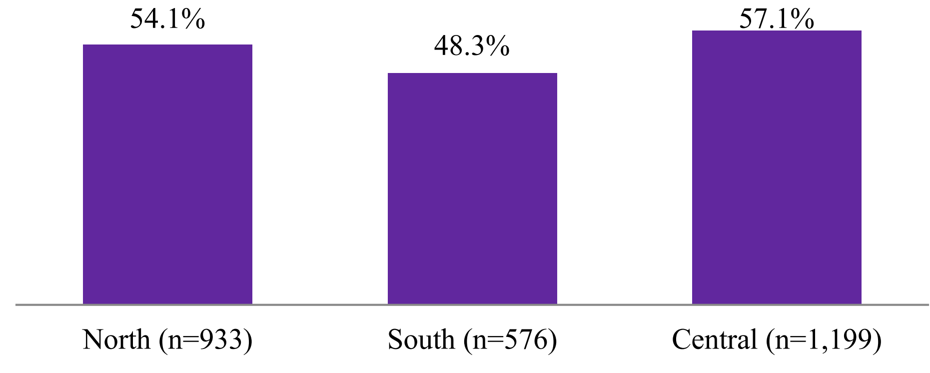
**CalOptima language:**




**Age Category:**



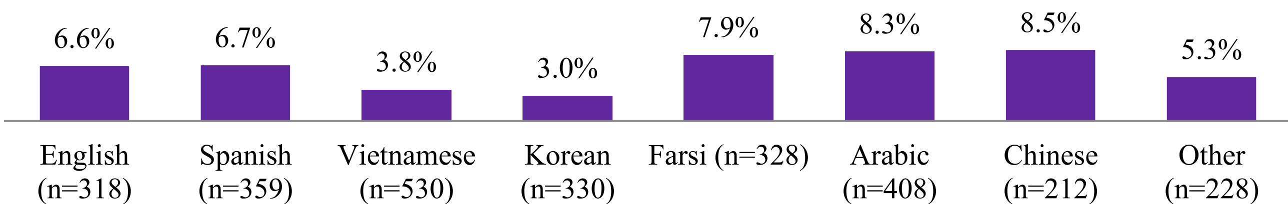

**Region:**



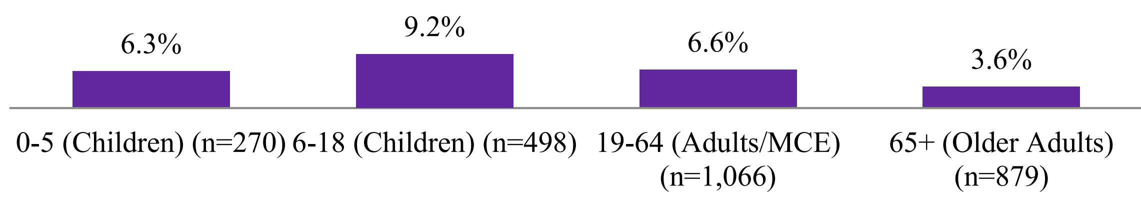

[8] Only reporting those who reported that they received at least one public benefit.

**Receive TANF or CalWorks as a public benefit:**

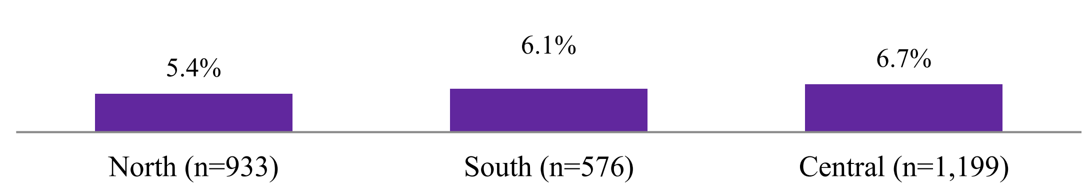
**CalOptima language:**




**Age Category:**

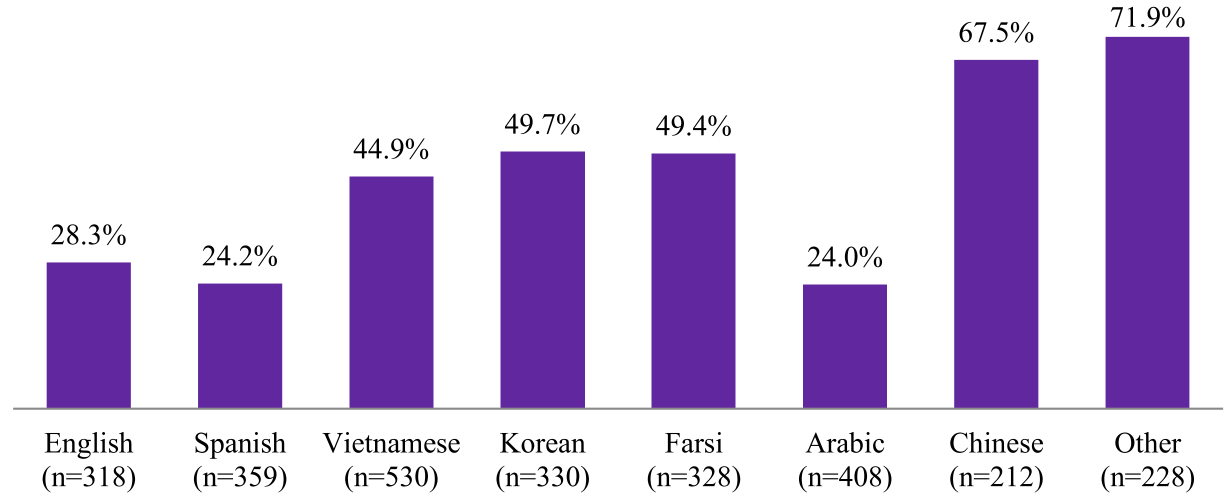



**Region:**

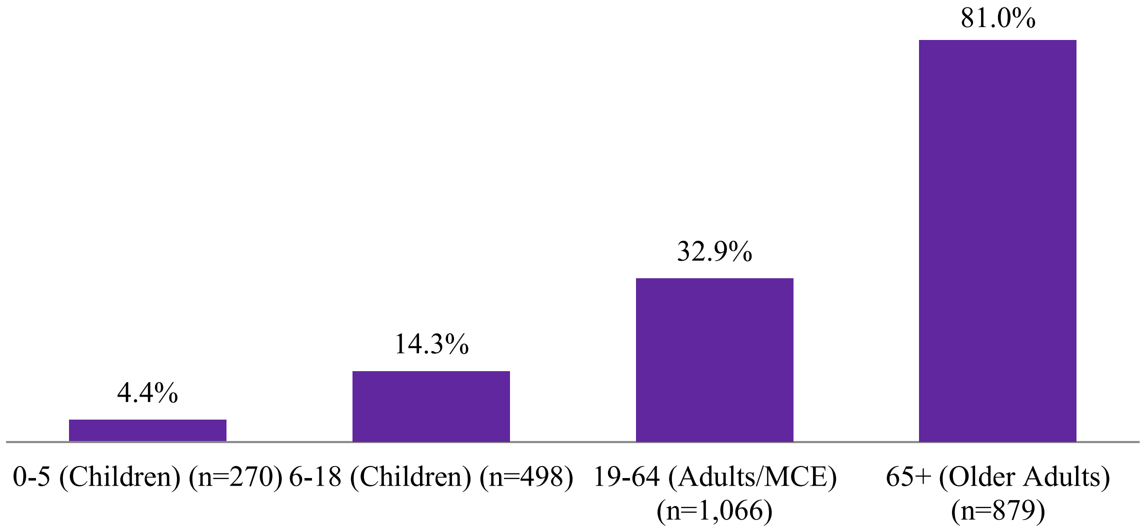


**Receive SSI or SSDI as a public benefit:**

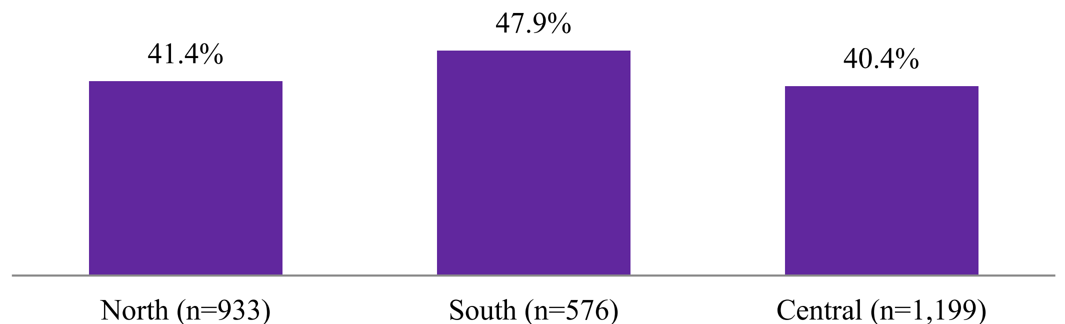
**CalOptima language:**




**Age Category:**

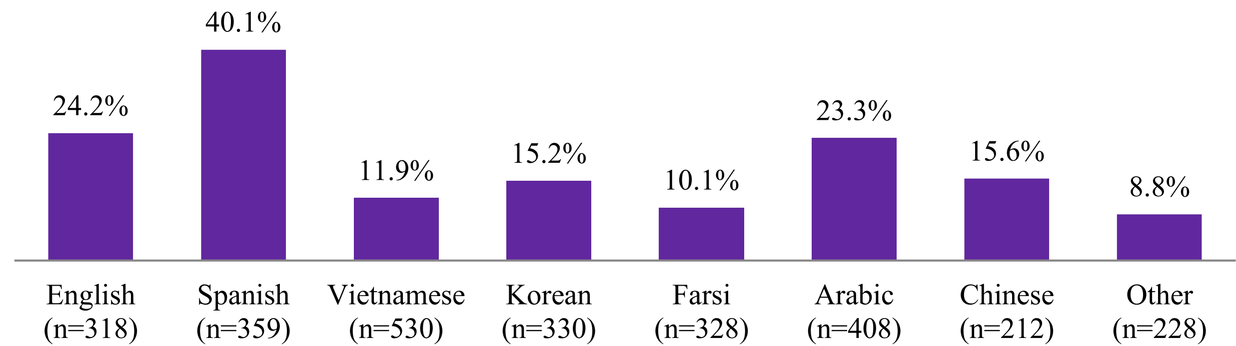



**Region:**

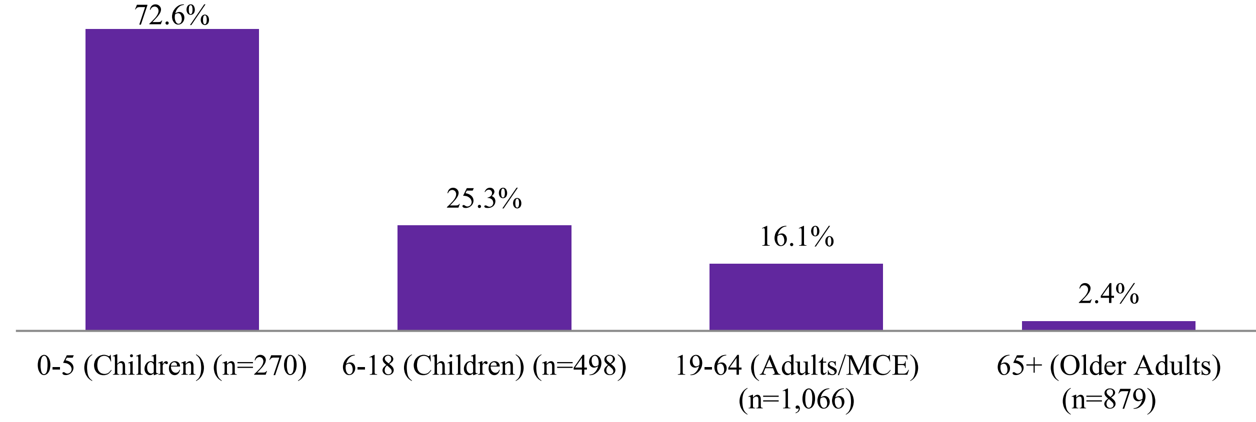


**Receive WIC as a public benefit:**

**CalOptima language:**




**Age Category:**




**Region:**

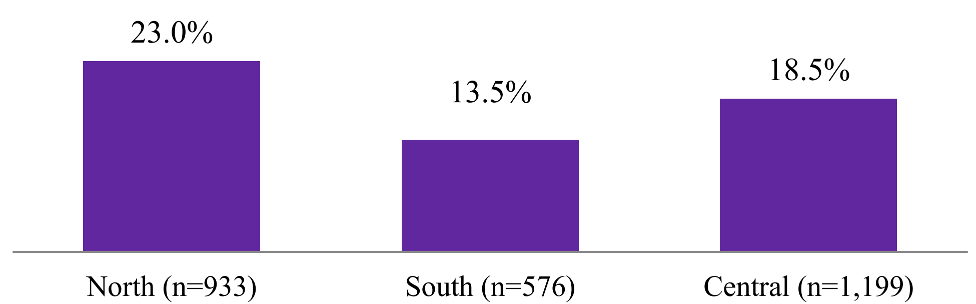


**Exhibit 15. Personal activities participation:**

**CalOptima language:**

| Care for a family member | Once a week<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>%** | **Once a month<br>%** | **Once in the last 6 months<br>%** | **Never<br>%** | **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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>%** | **Once a month<br>%** | **Once in the last 6 months<br>%** | **Never<br>%** | **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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>%** | **Once a month<br>%** | **Once in the last 6 months<br>%** | **Never<br>%** | **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<br>%** | **Once a month<br>%** | **Once in the last 6 months<br>%** | **Never<br>%** | **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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>%** | **Once a month<br>%** | **Once in the last 6 months<br>%** | **Never<br>%** | **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<br>%** | **Once a month<br>%** | **Once in the last 6 months<br>%** | **Never<br>%** | **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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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:**

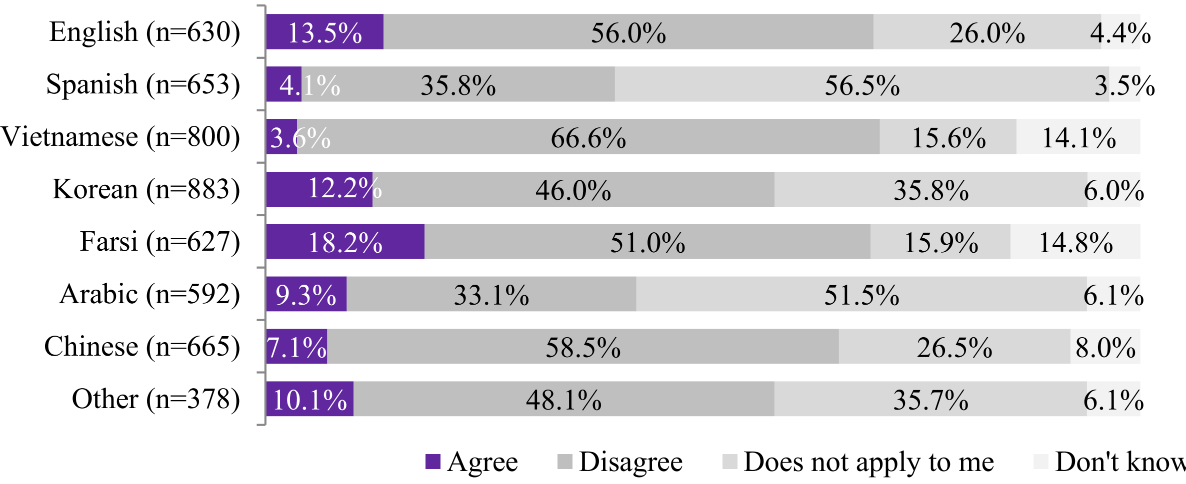
| Care for a family member | Once a week % | Once a month % | Once in the last 6 months % | Never % | n |
|---|---|---|---|---|---|
| **North** | 35.3% | 5.4% | 3.7% | 55.6% | 1,639 |
| **South** | 28.8% | 4.2% | 4.0% | 62.9% | 1,252 |
| **Central** | 38.8% | 4.4% | 3.4% | 53.4% | 1,910 |
| **Do fun 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<br>% | Once a month<br>% | Once in the last 6 months<br>% | Never<br>% | 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<br>%** | **Once a month<br>%** | **Once in the last 6 months<br>%** | **Never<br>%** | **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<br>%** | **Once a month<br>%** | **Once in the last 6 months<br>%** | **Never<br>%** | **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 |

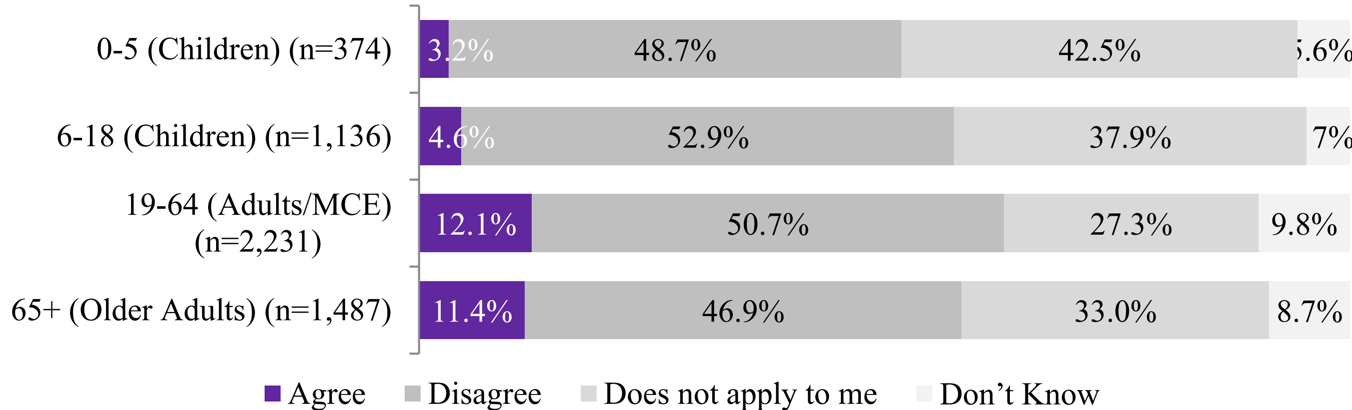
**Exhibit 16. Feelings towards community and home enviroment:**

**Feeling lonely and isolated:**

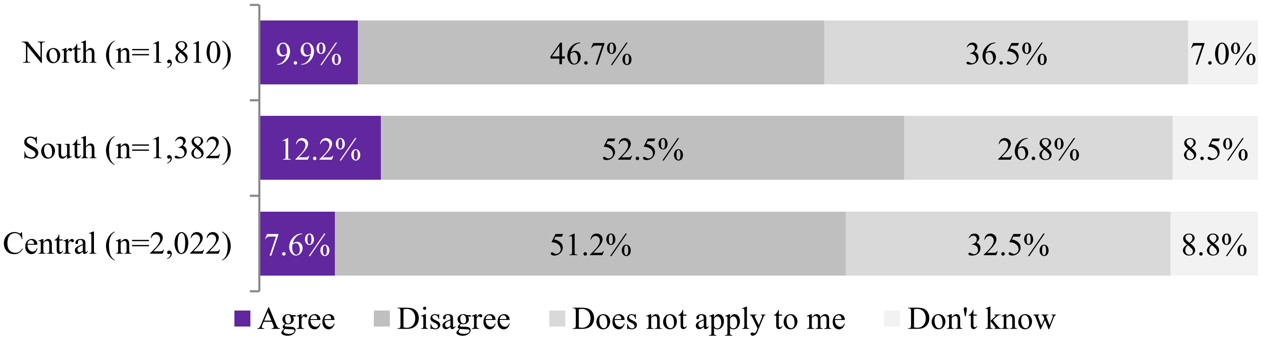
**CalOptima language:**




**Age Category:**

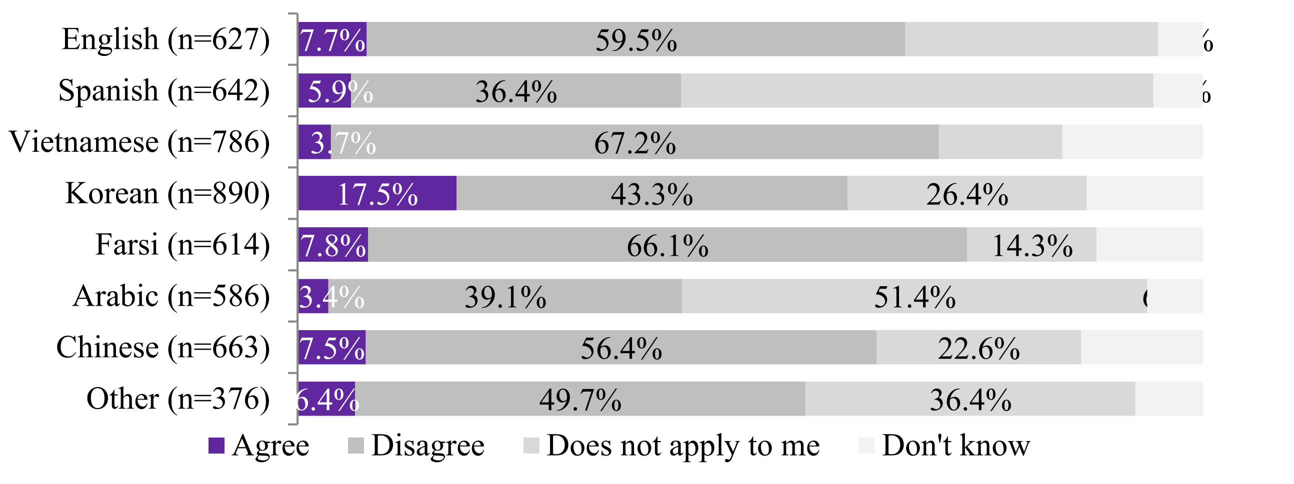



**Region:**

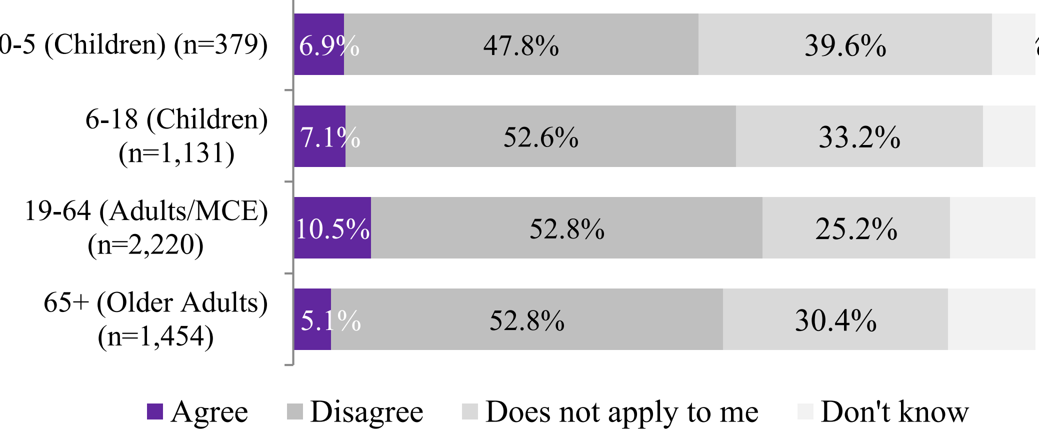


**Feel not treated equally because of ethnic and cultural backgrounds:**

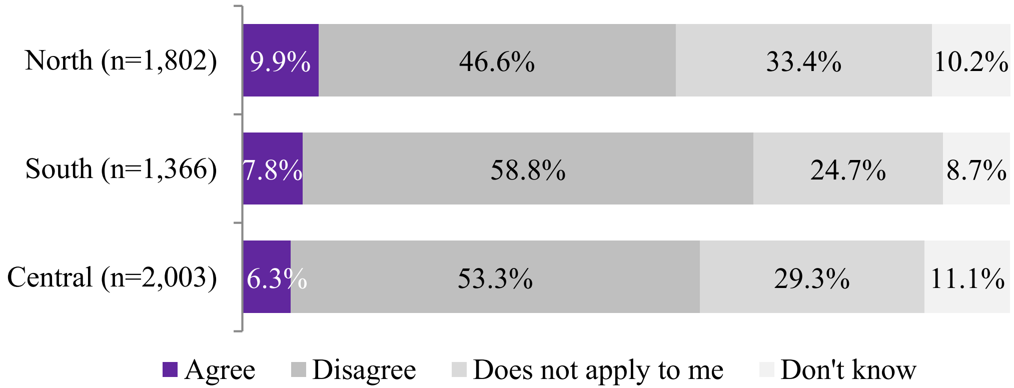
**CalOptima language:**




**Age Category:**

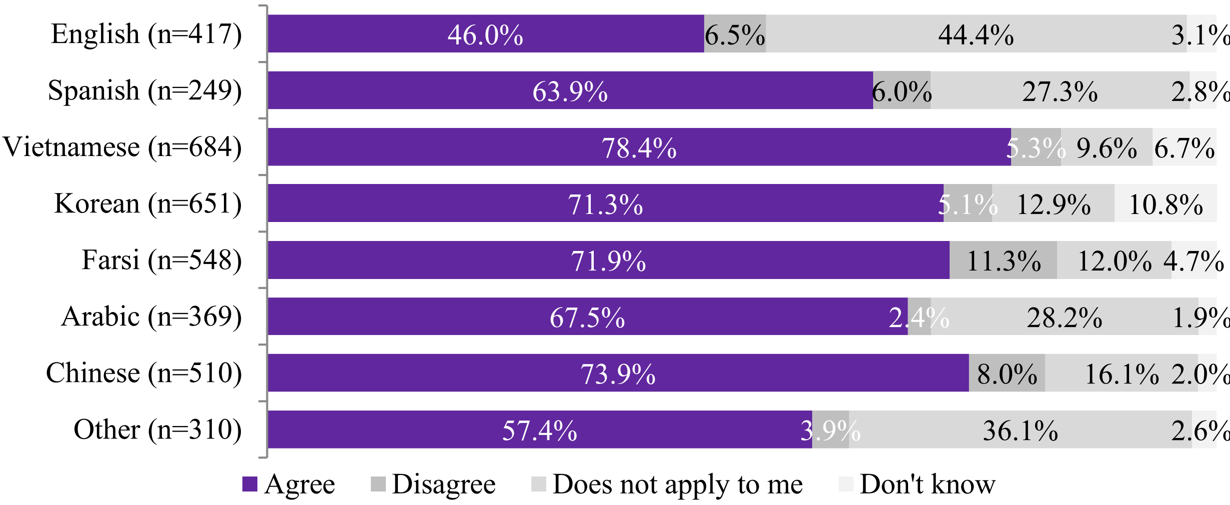



**Region:**



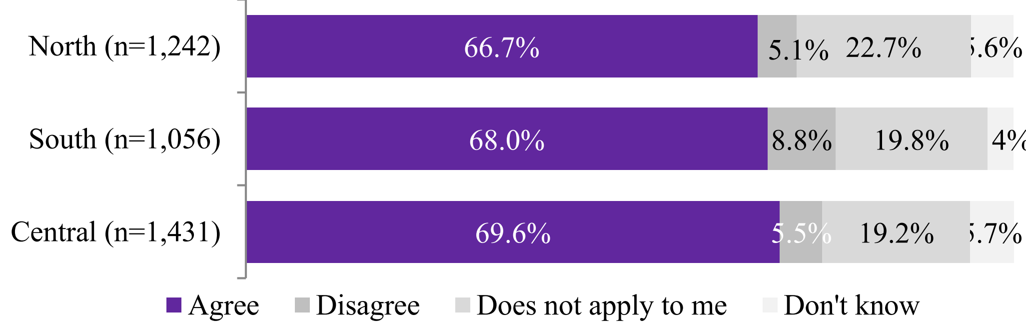
**Feel child respects them as a parent[9]:**

**CalOptima language:**




**Age Category:**

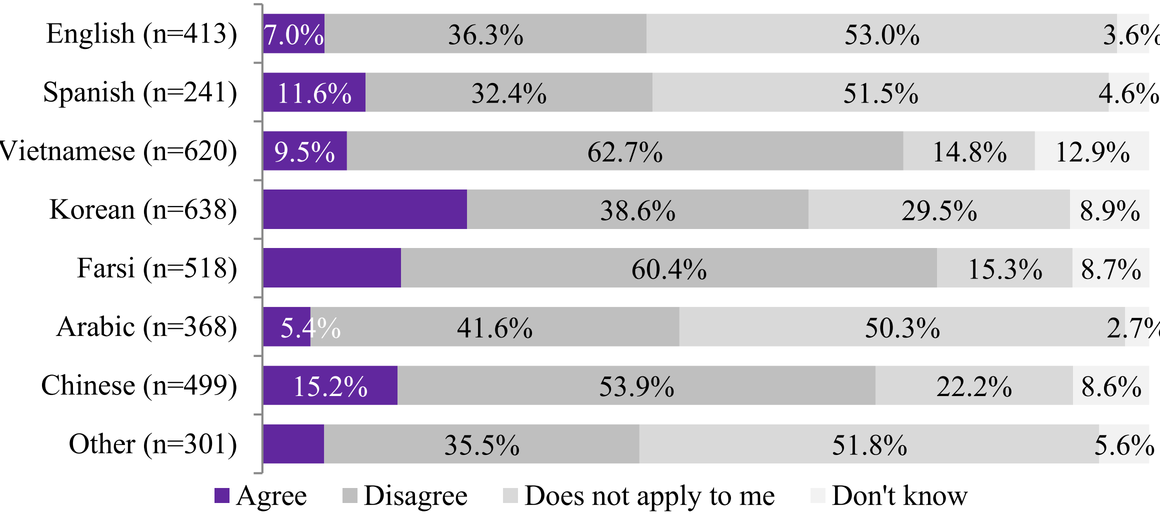
**Region:**



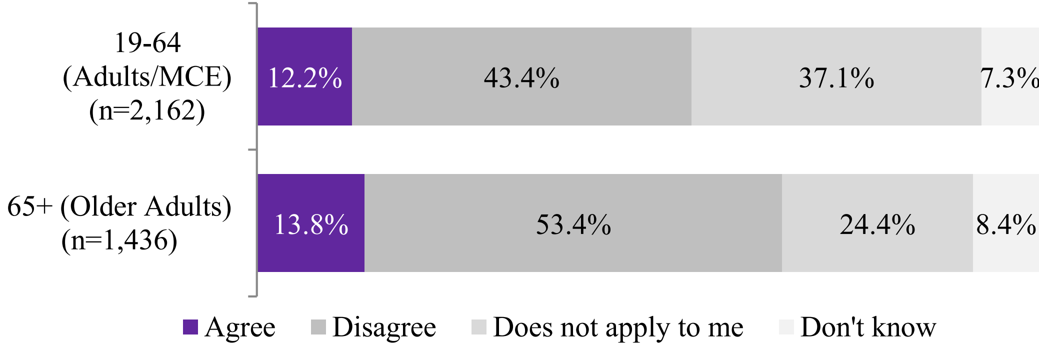

[9] Only reported those who are over 18 years old.

**Feel child's attitudes and behavior conflict with cultural values[10]:**

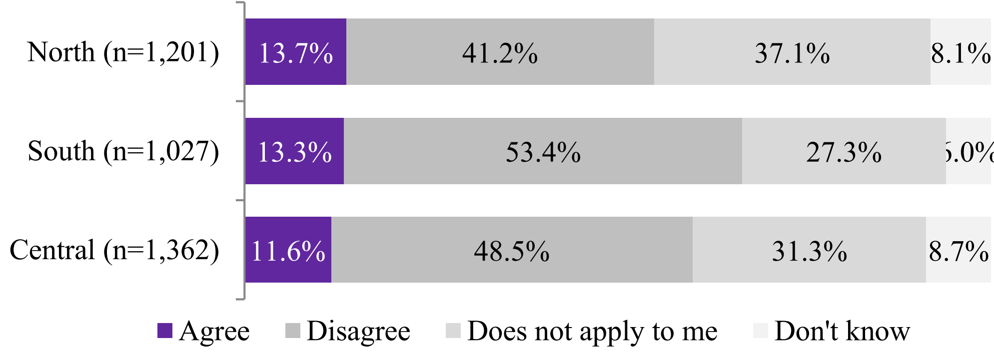
**CalOptima language:**




**Age Category:**



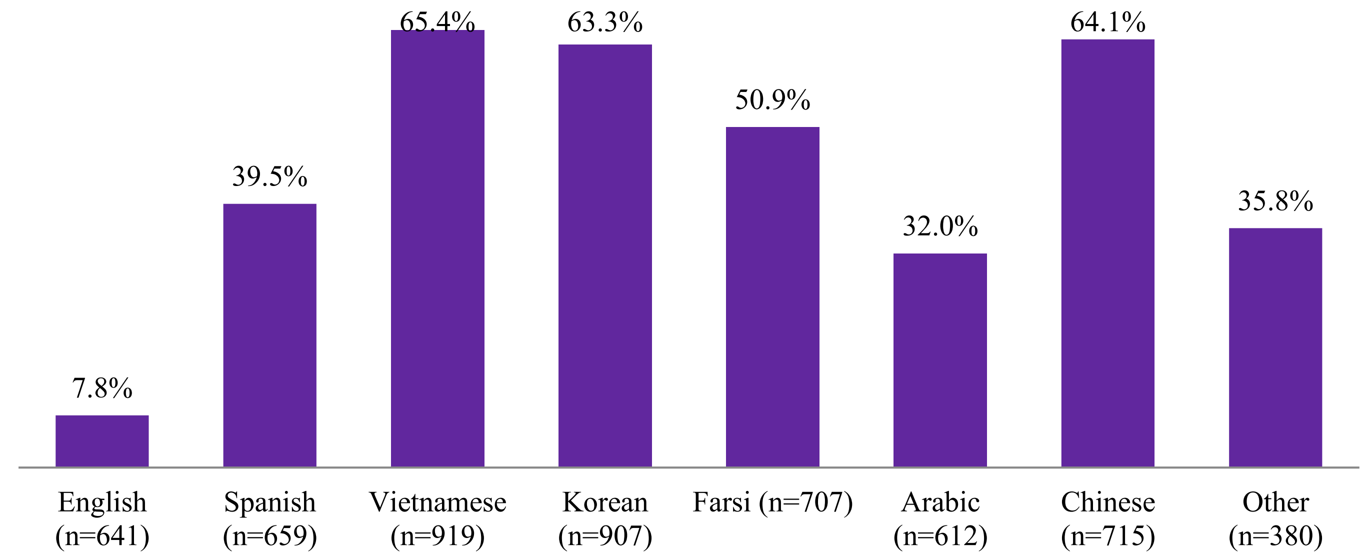

**Region:**



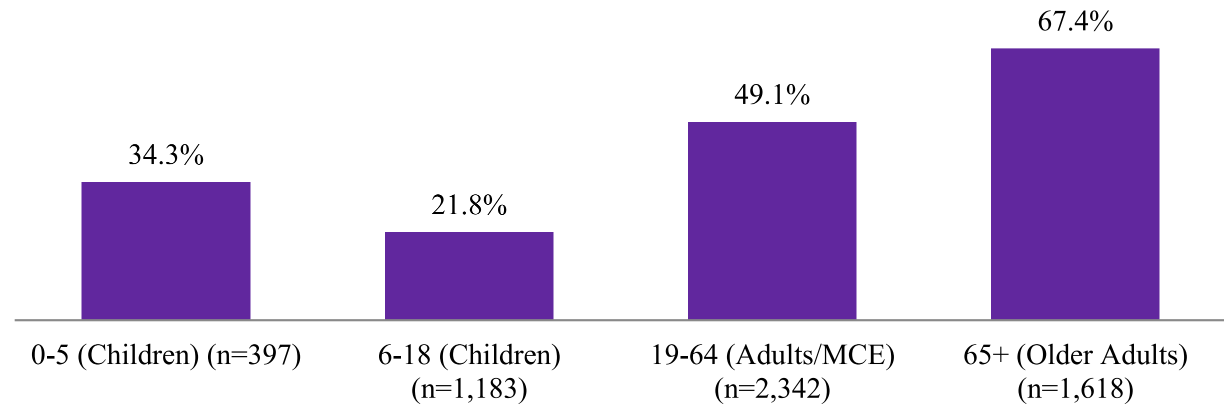

[10] Only reported those who are over 18 years old.

**Exhibit 17. Members who reported that they speak English "not well":**

**CalOptima language:**




**Age Category:**




**Region:**

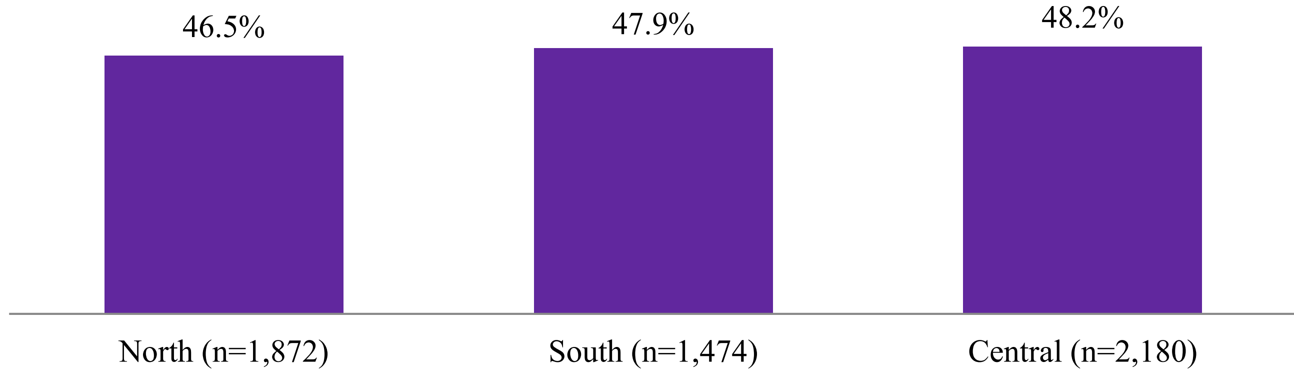


**Exhibit 18. Employment status[11,12]**

**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:**

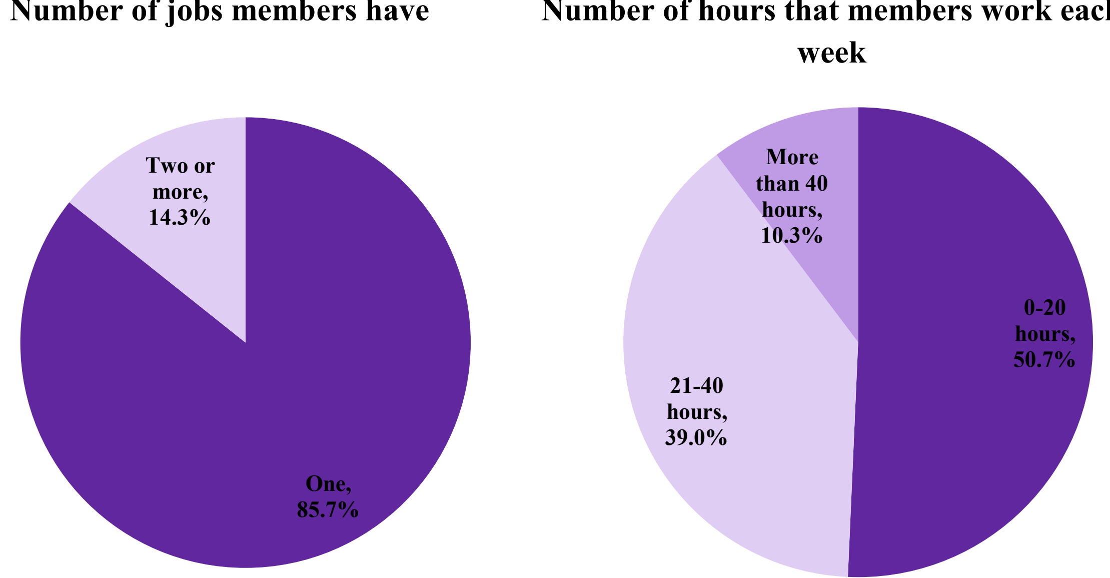
| Age Category | Employed % | Self employed % | Homemaker % | Student % | Retired % | Out of work % | Unable to work % | n |
|---|---|---|---|---|---|---|---|---|
| **19-64 (Adults/MCE)** | 35.8% | 8.3% | 17.5% | 10.9% | 5.9% | 17.6% | 15.3% | 2,370 |
| **65+ (Older Adults)** | 4.1% | 1.7% | 10.1% | 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 |

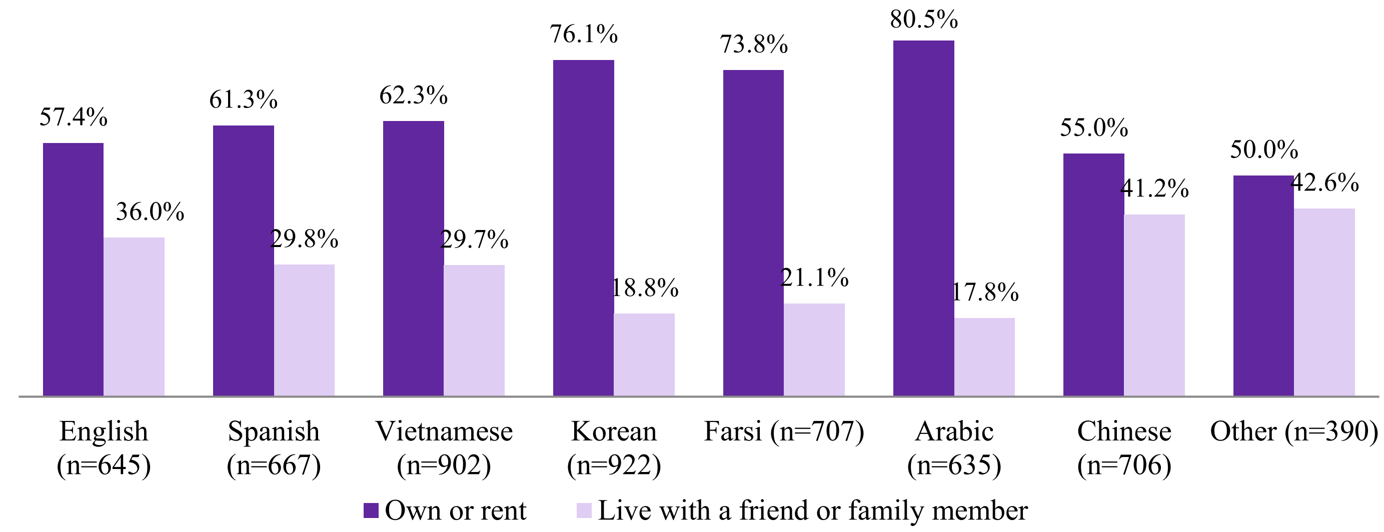
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

**Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]**

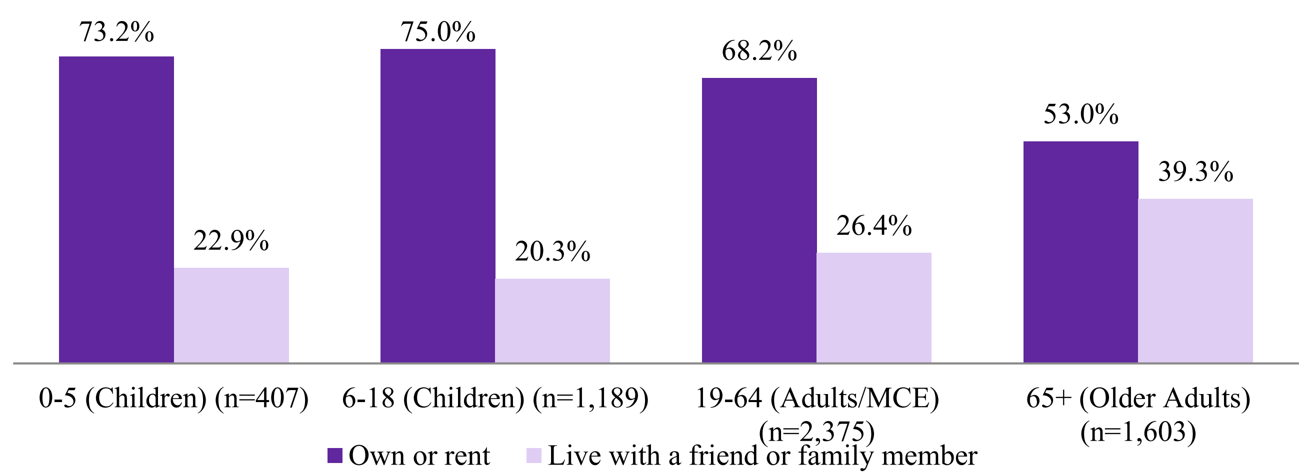



[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

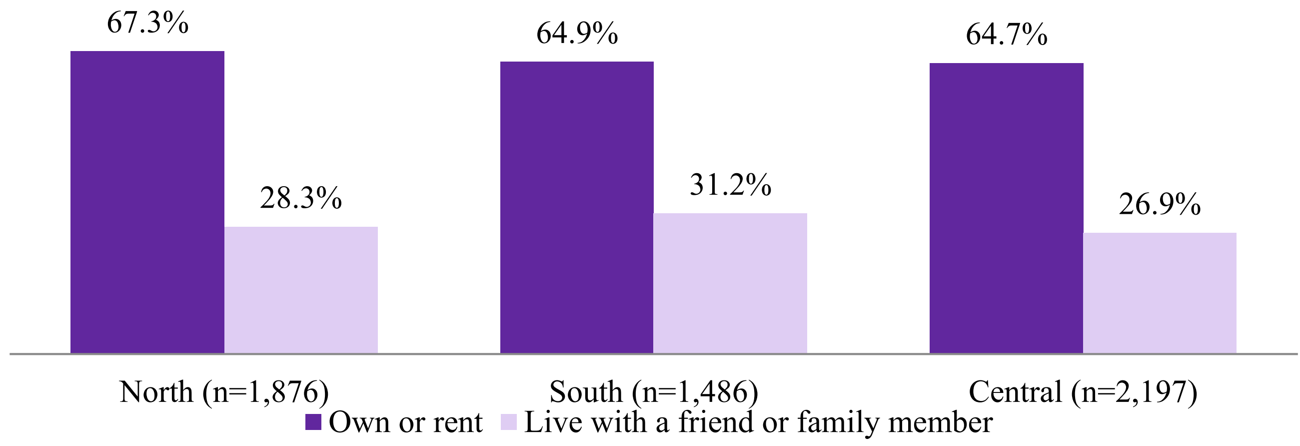
**Exhibit 20. Members' living situation[14]**




**Age Category:**



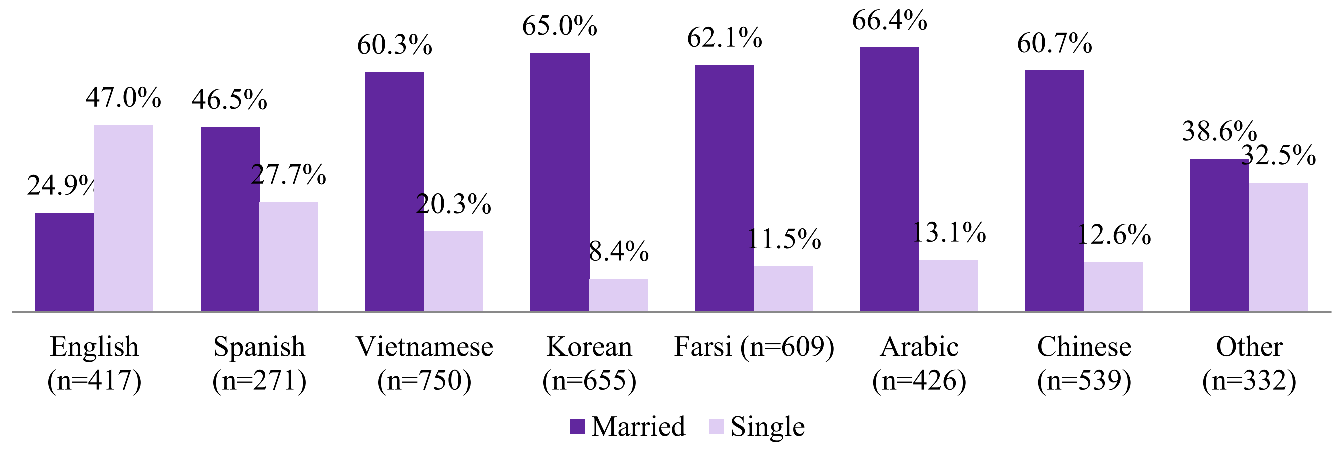

**Region:**



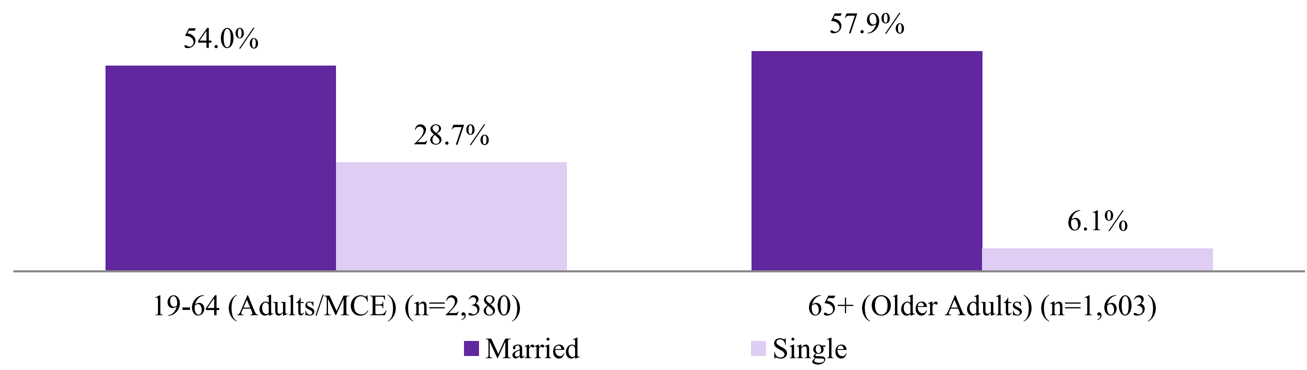

[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

**Exhibit 21. Marital status of members[15],[16]**

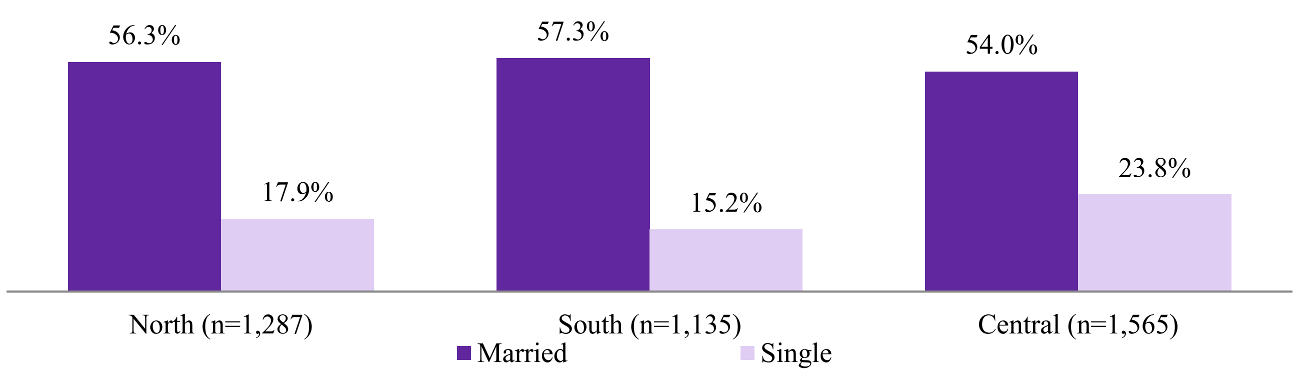
**CalOptima language:**




**Age Category:**



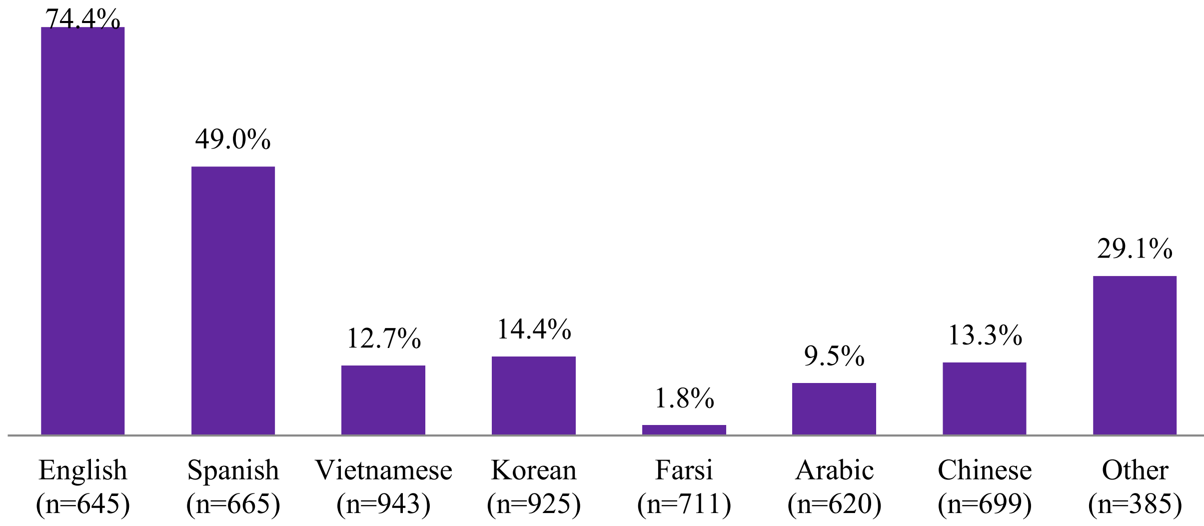

**Region:**



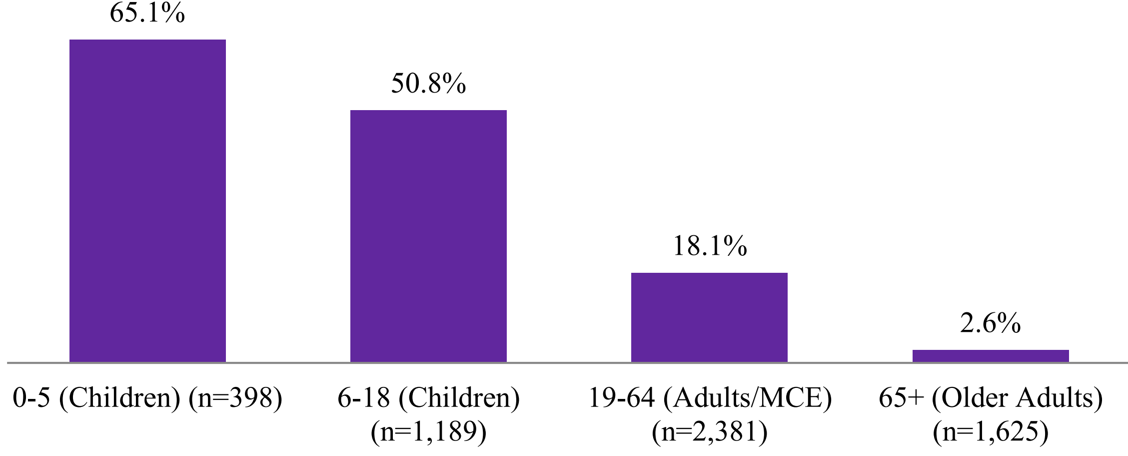

[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

**Exhibit 22. Percent of members who were born in the United States:**

**CalOptima language:**




**Age Category:**




**Region:**

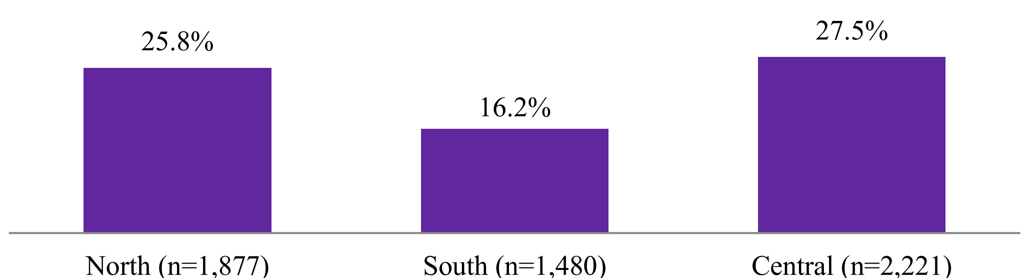
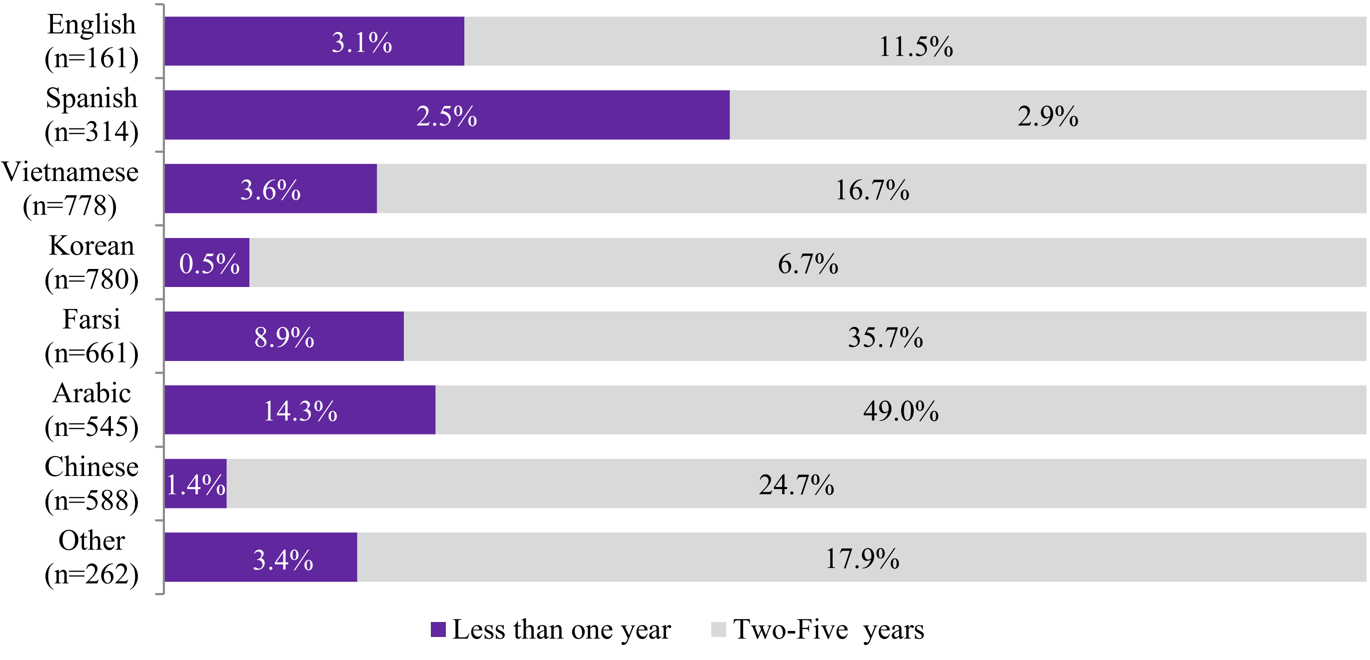
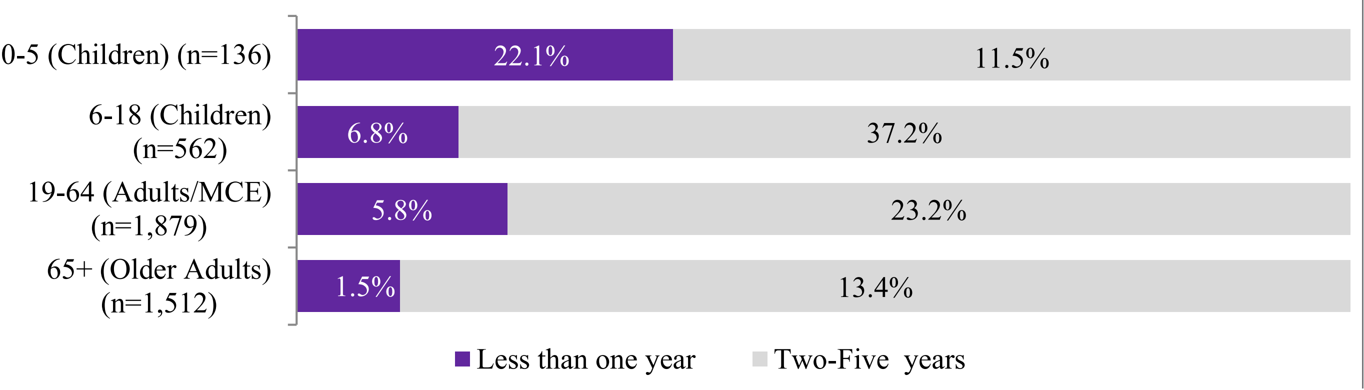


**Exhibit 23. Length of time lived in the United States of those not born in the United States**

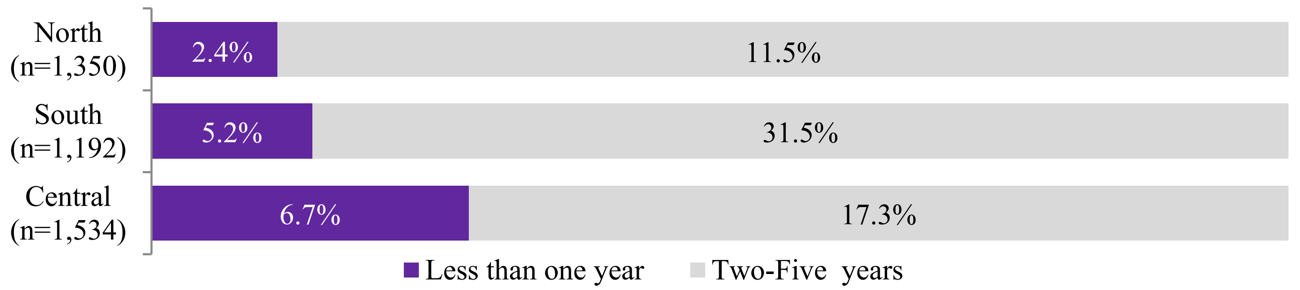
**CalOptima language:**




**Age Category:**



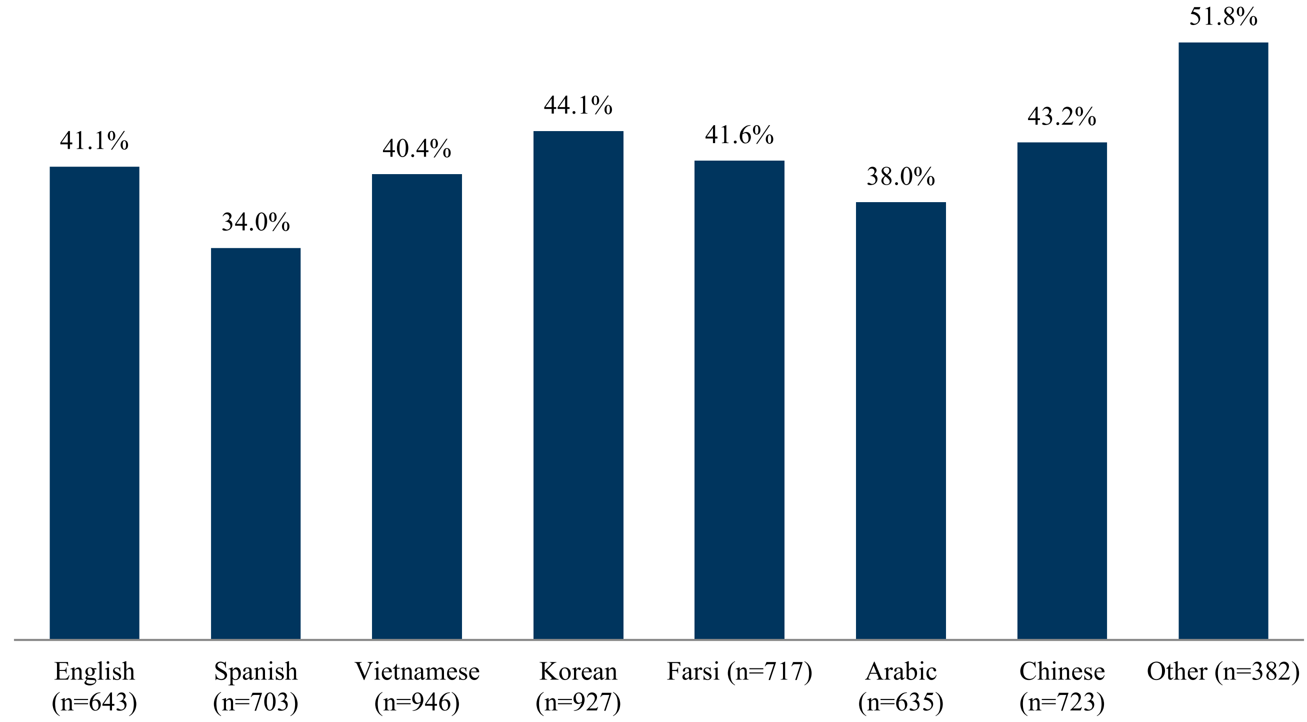

**Region:**



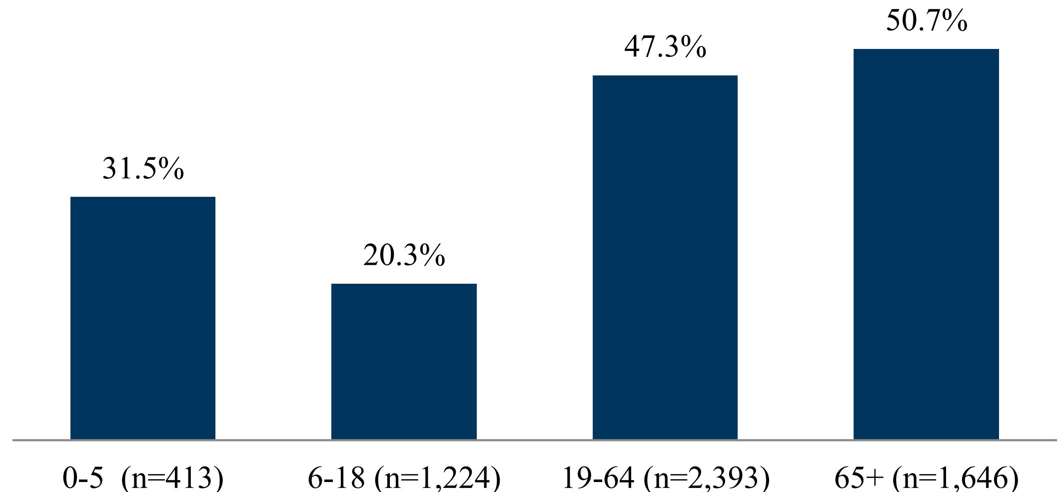
# Health Behaviors

**Exhibit 24. Percent of members who have not seen a dentist within the past 12 months**

**CalOptima language:**




**Age Category:**



**Region:**

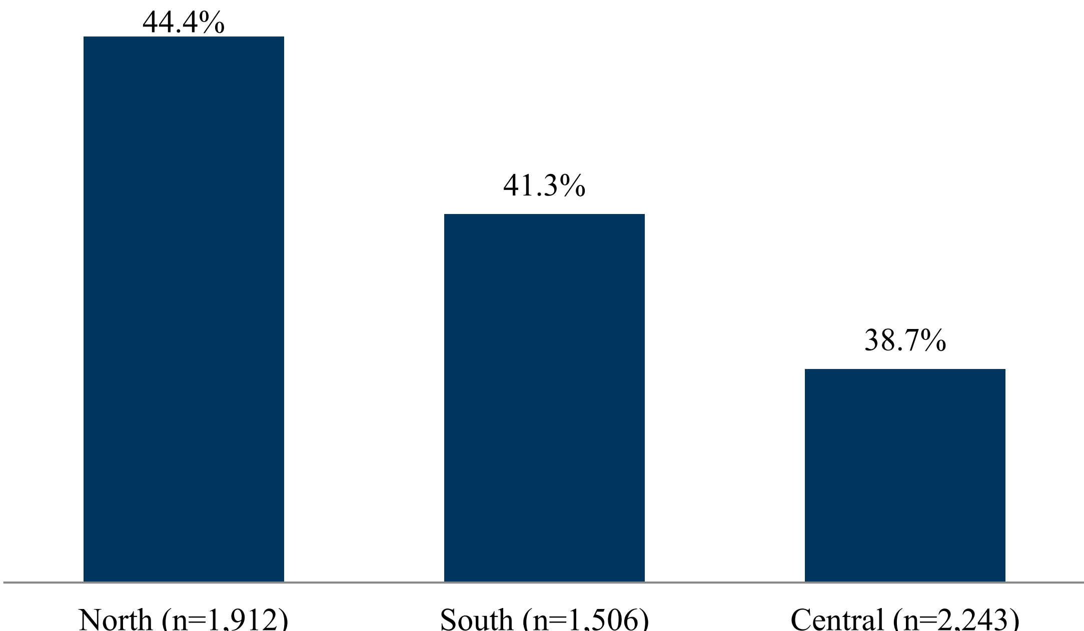


**Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]**

**CalOptima Language:**

| CalOptima Language | Cost<br>% | Don't have/know dentist<br>% | No transportation<br>% | Don't know<br>% | 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<br>% | Don't have/know dentist<br>% | No transportation<br>% | Don't know<br>% | 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<br>% | Don't have/know dentist<br>% | No transportation<br>% | Don't know<br>% | 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<br>% | 1 2 days per week<br>% | 3 4 days per week<br>% | 5 7 days per week<br>% | Don't know<br>% | 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

# Navigating the Healthcare System

**Exhibit 27. Percent who report at least one person as their doctor (n=5,749)**

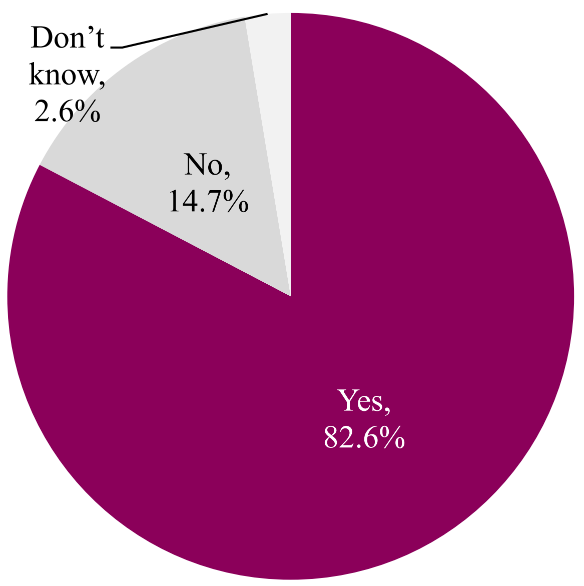



**Exhibit 28. Where respondents go to see their doctor (n=5,743)**

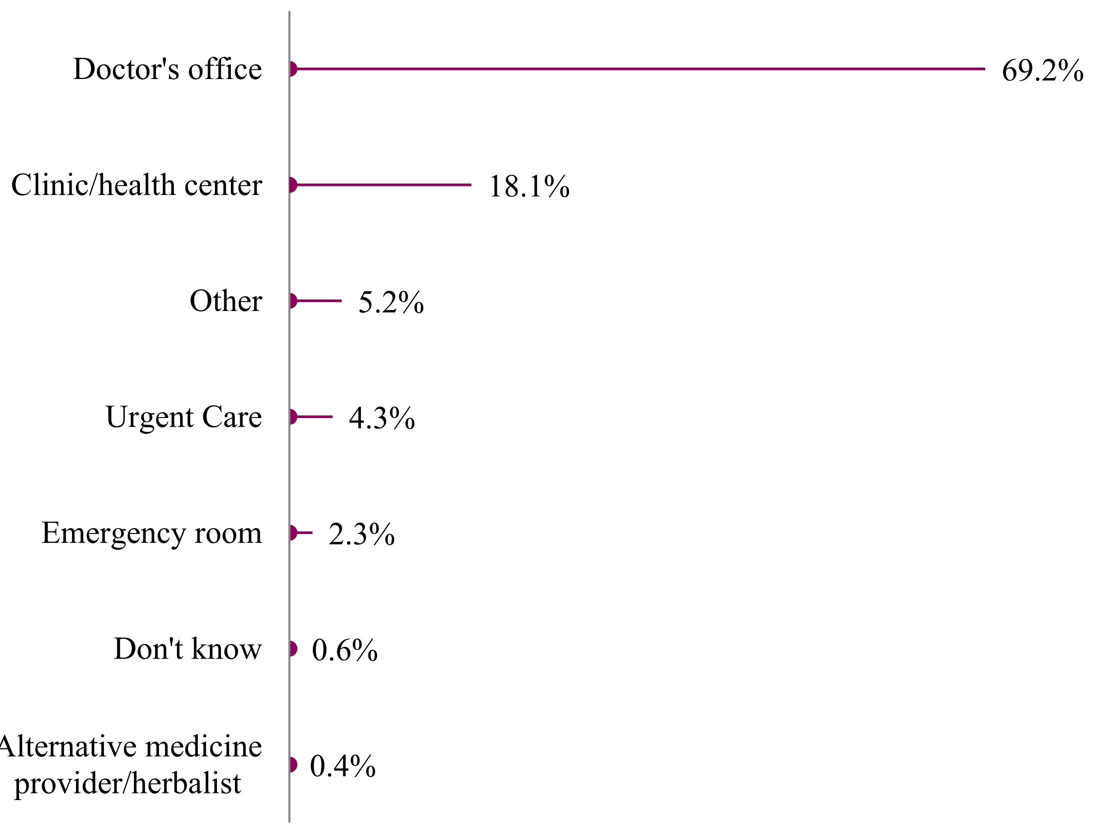


**Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)**

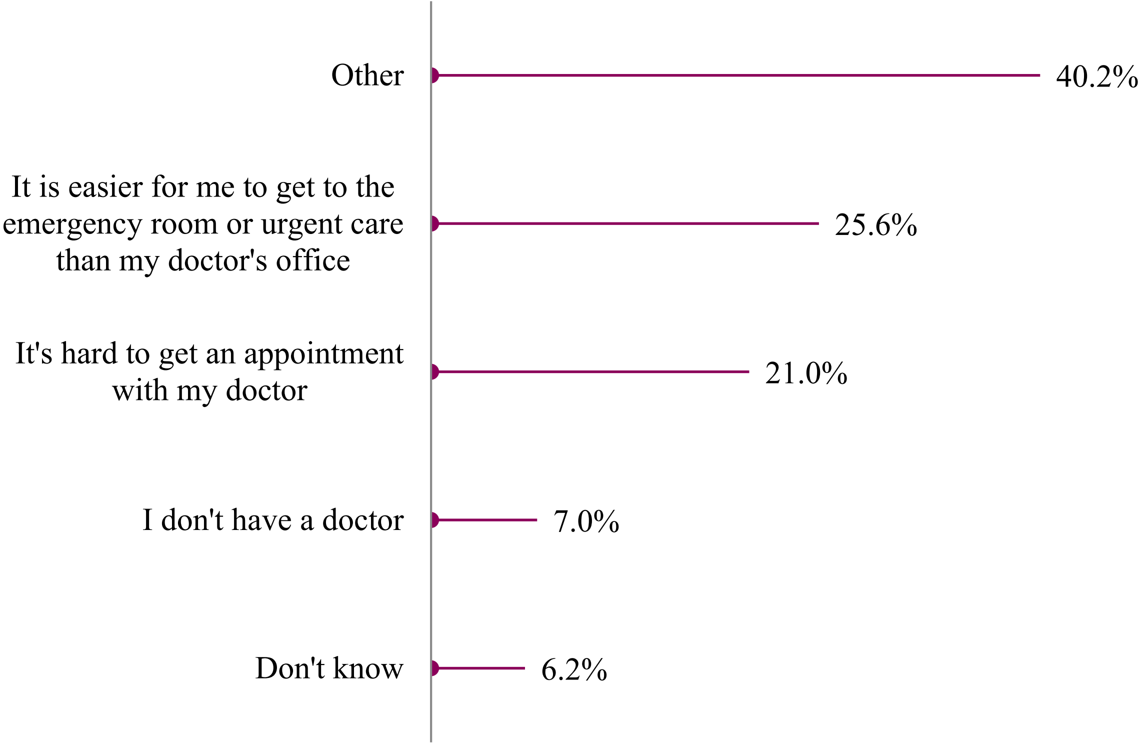


**Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]**

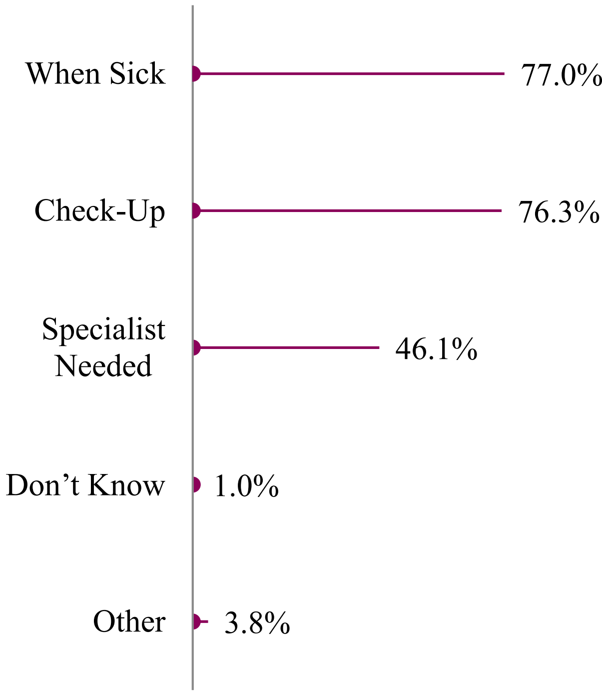
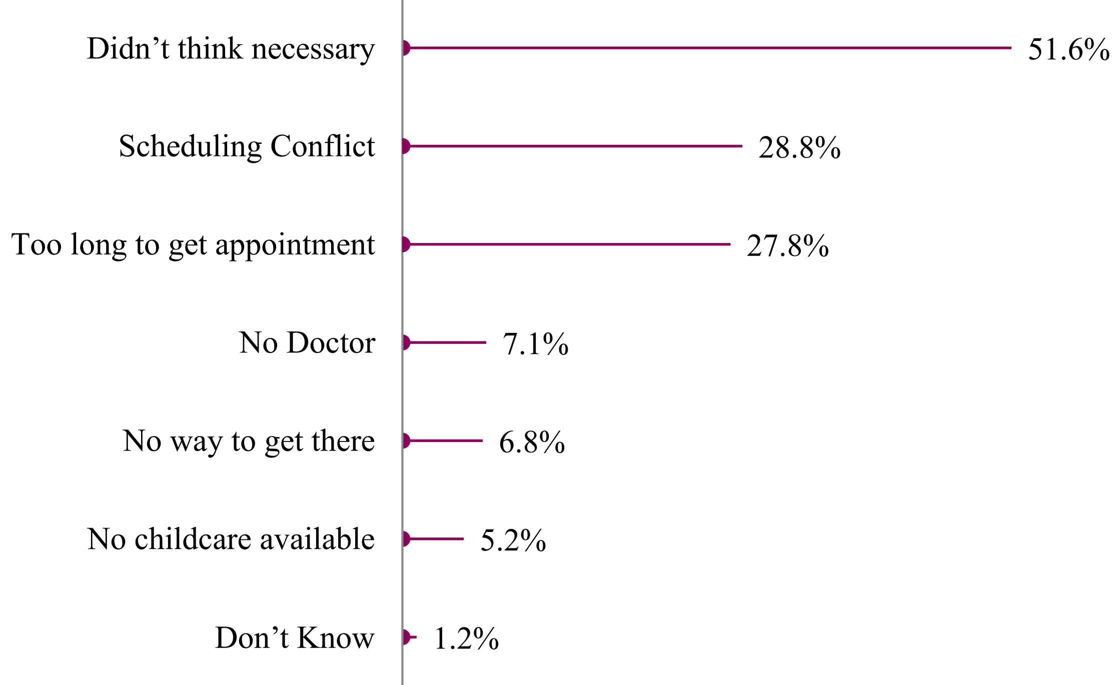



**Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]**




[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%.



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**Exhibit 32. When do members make an appointment to see a specialist (n=5,590)[22]**

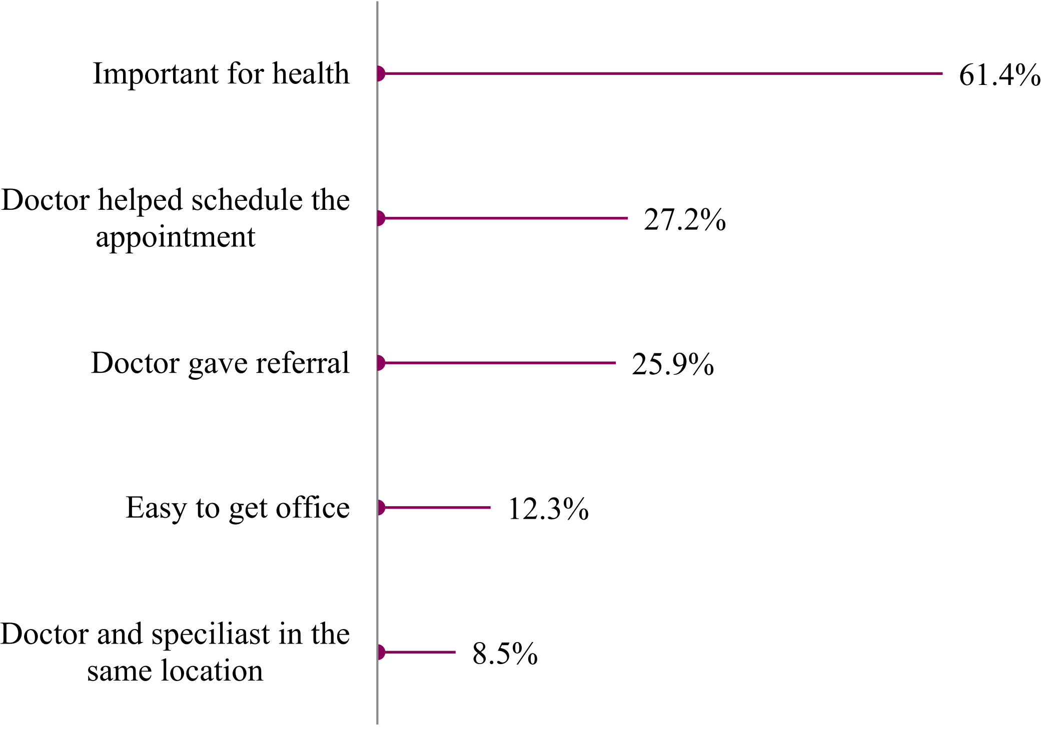
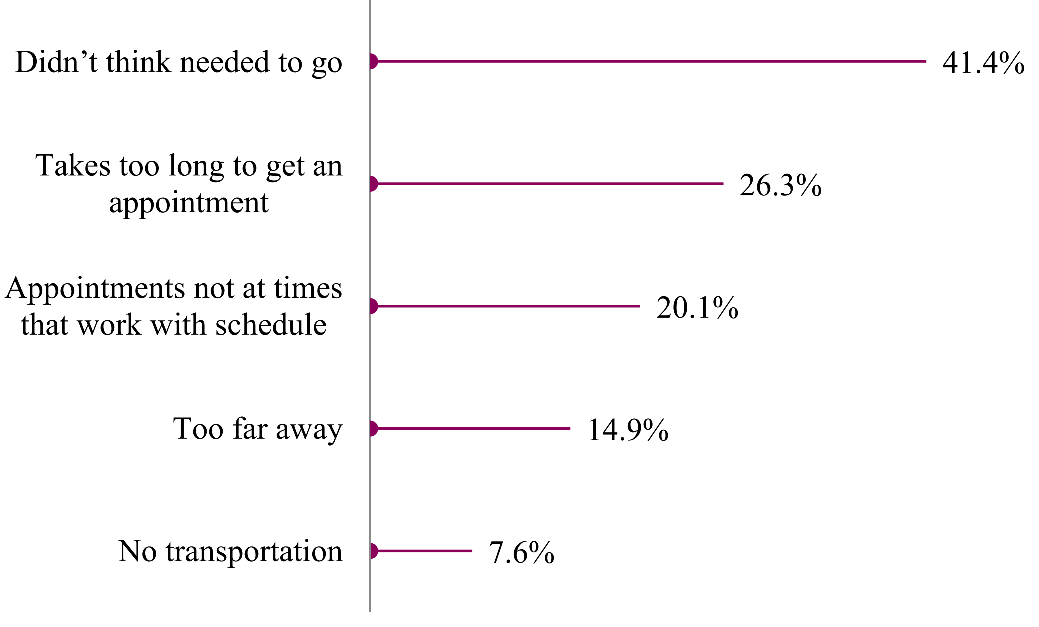



**Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]**




[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%.



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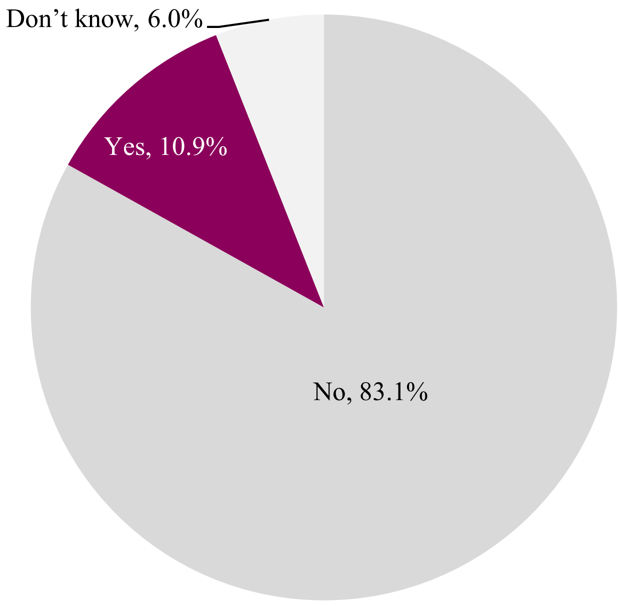
**Exhibit 34. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor (n=4,955)**



# Social and Emotional Well-Being

**Exhibit 35. Percent of members who indicated they needed to see a mental health specialist (n=5,723)**

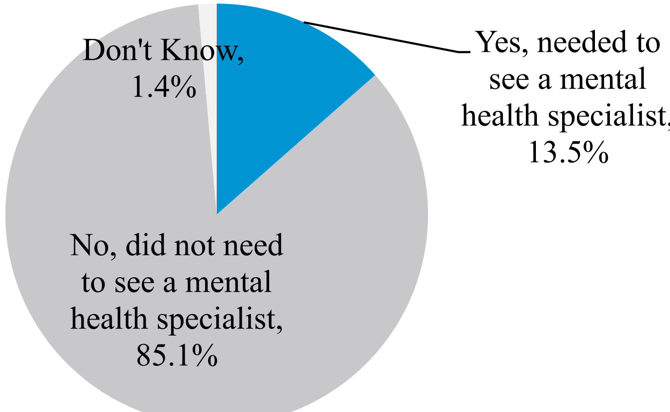



**Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)**

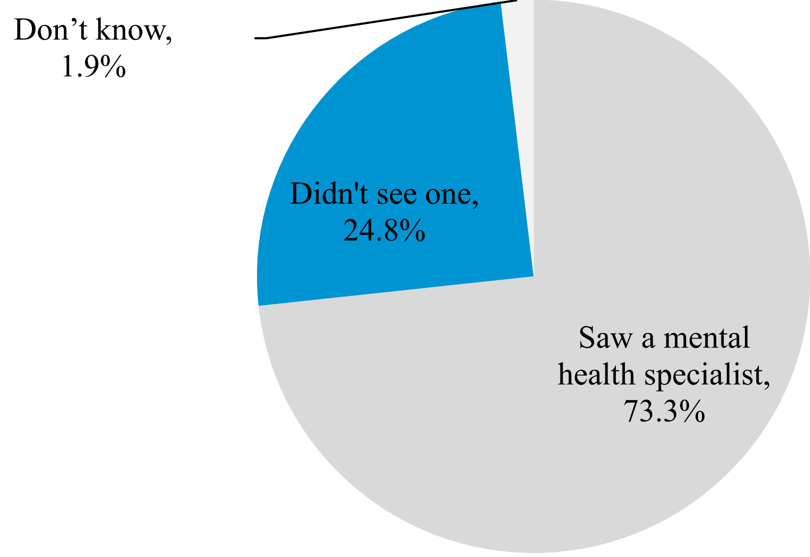


**Exhibit 37. Reasons why members didn't see mental health specialist[24]**

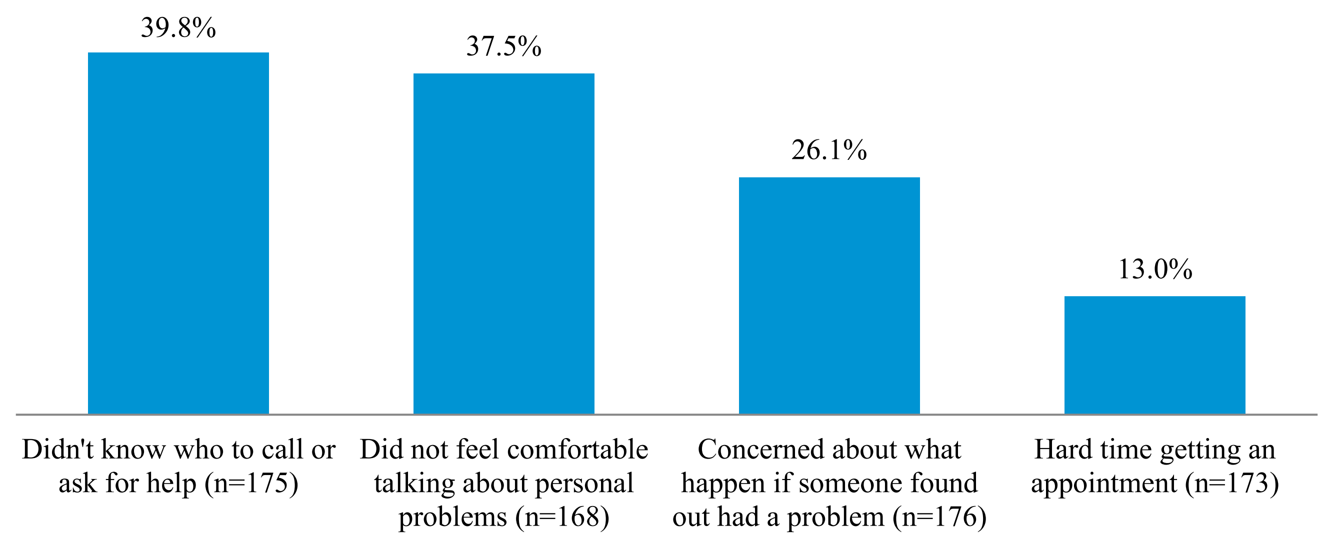
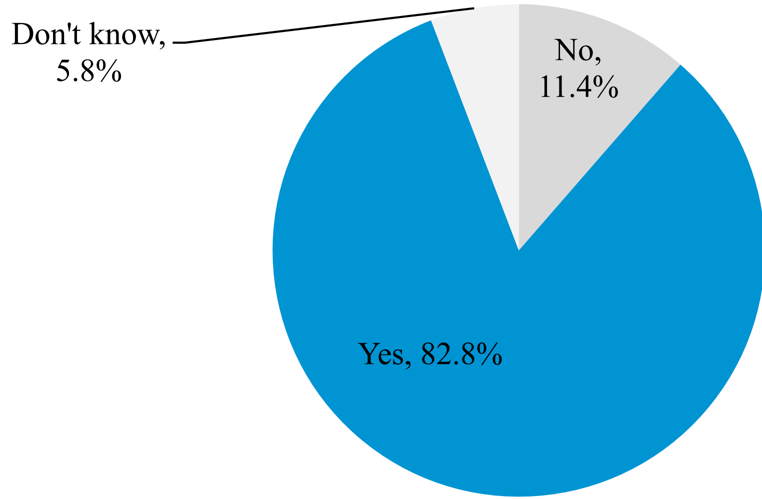



**Exhibit 38. Percent of members who can share their worries with family members (n=5,670)**




[24] Among those who indicated that they needed to see a mental health specialist but did not see one.



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# Social Determinants of Health

**Exhibit 39. Percent of members who needed help with basic needs in the past 6 months:**

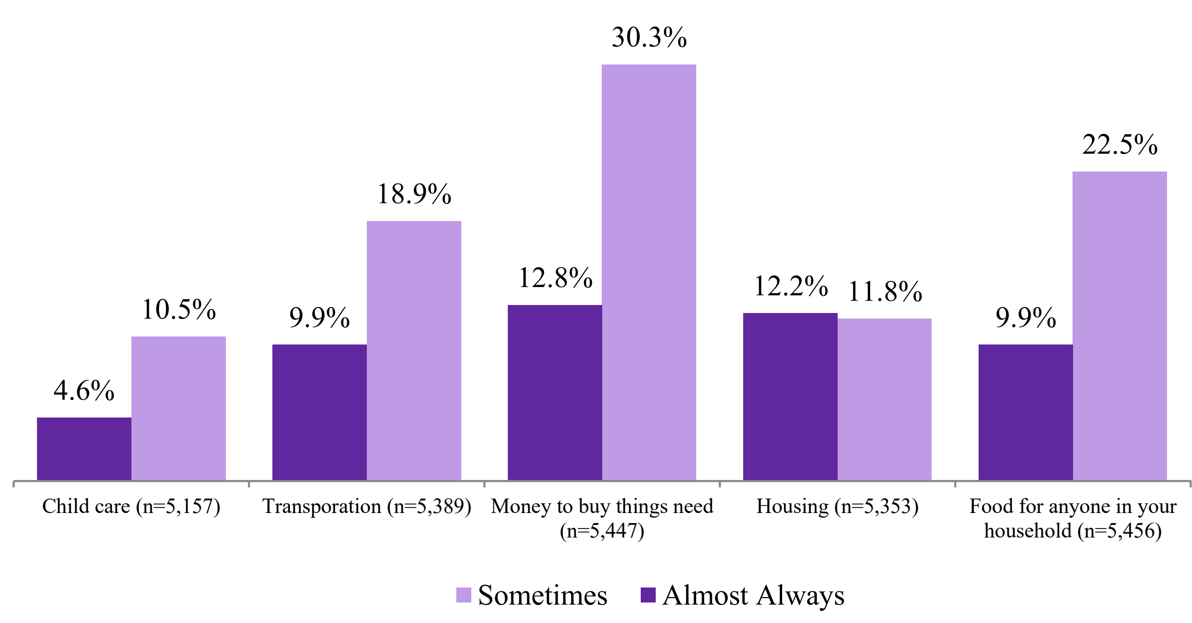


**Exhibit 41. Percent of members who receive public benefits (n=5,117):**

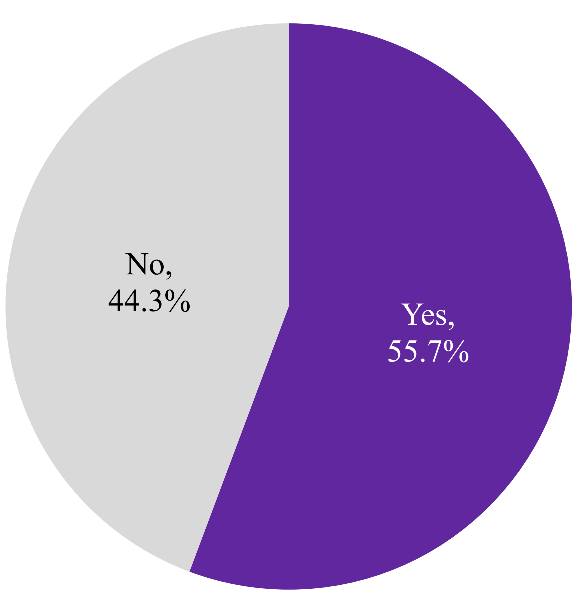
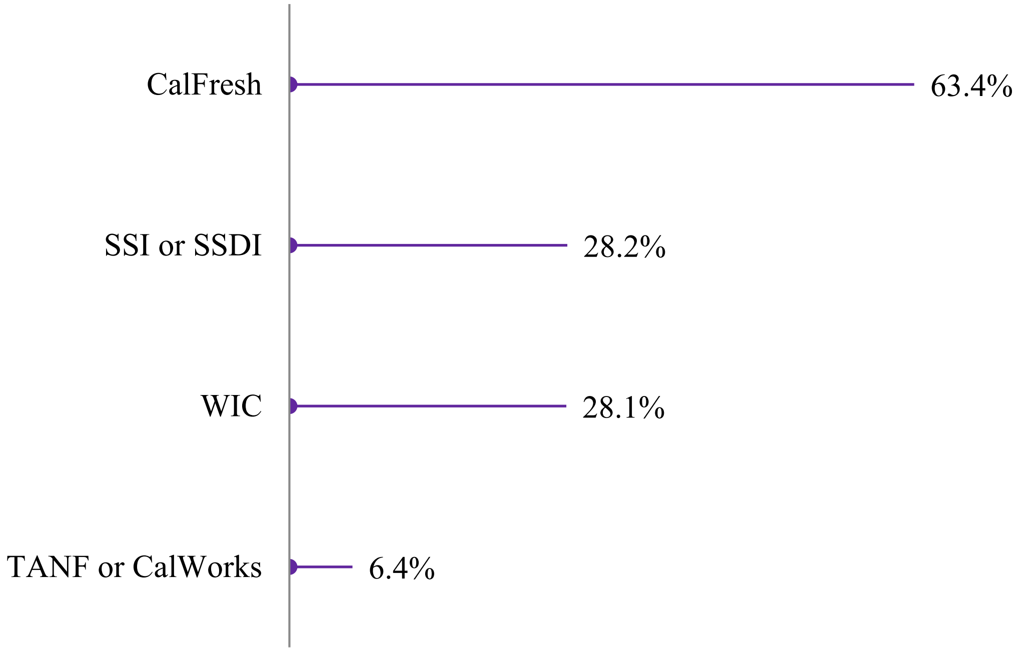



**Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:**

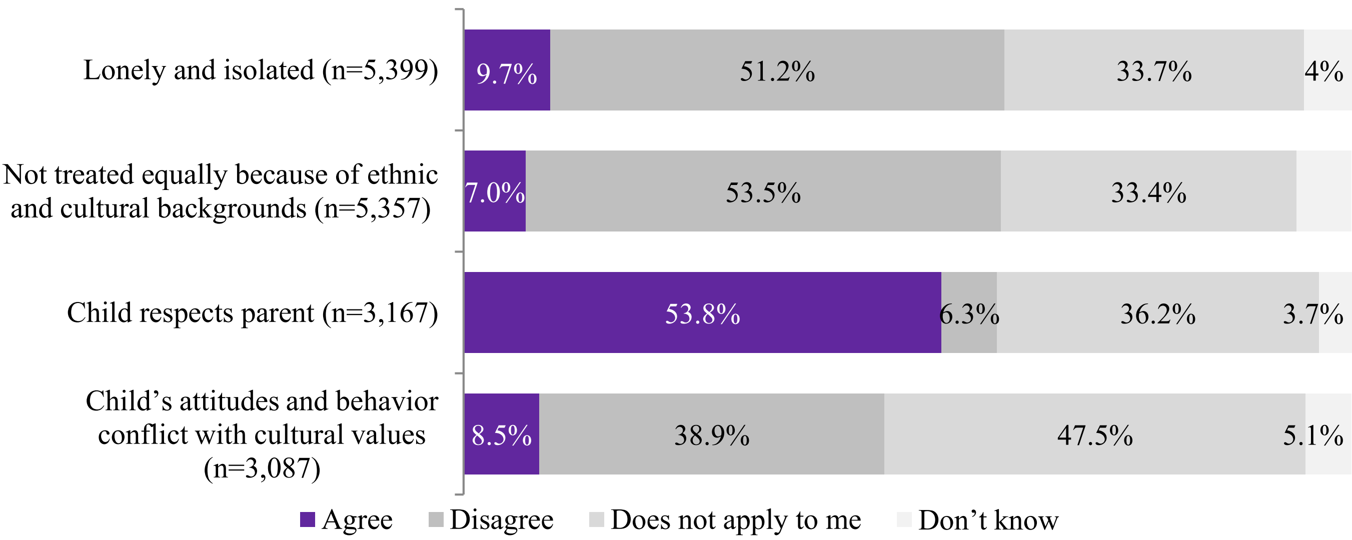



[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

**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% | |
| **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)**

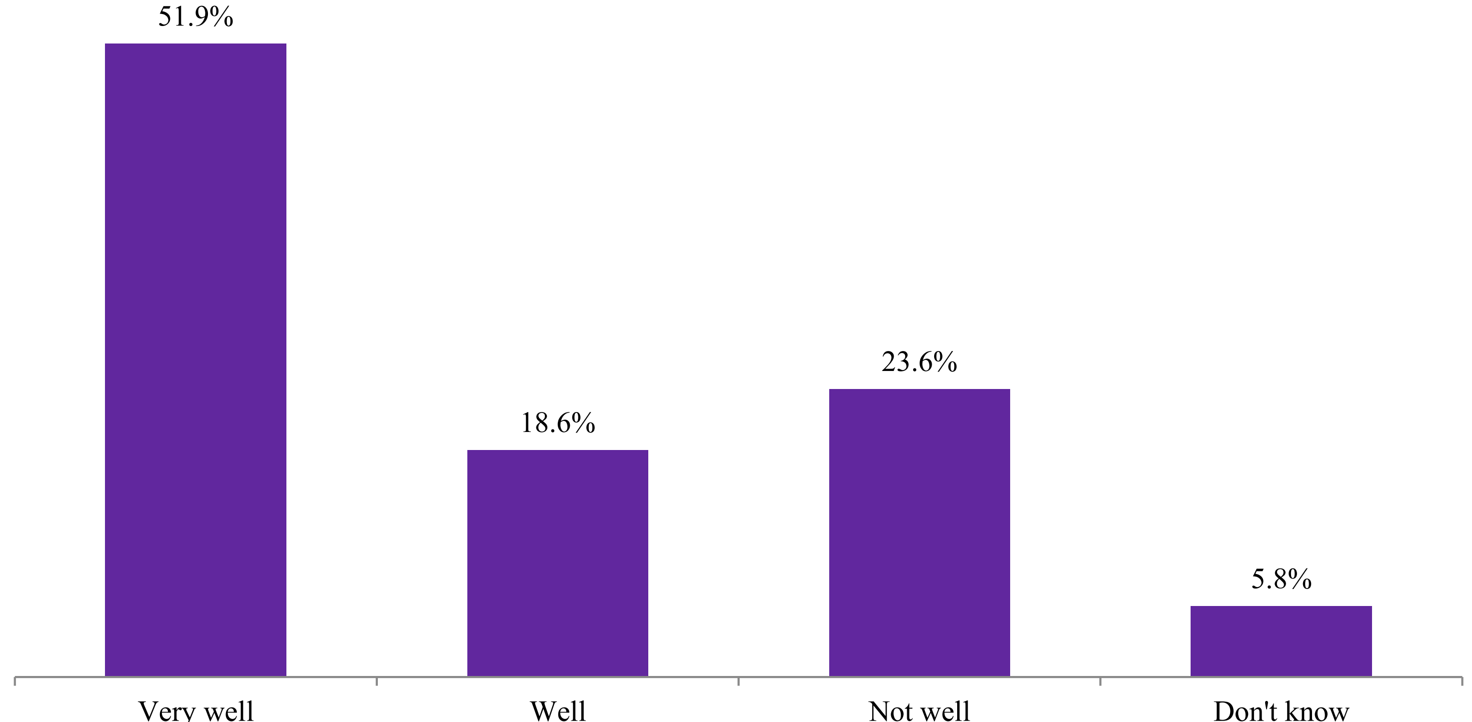


**Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]**

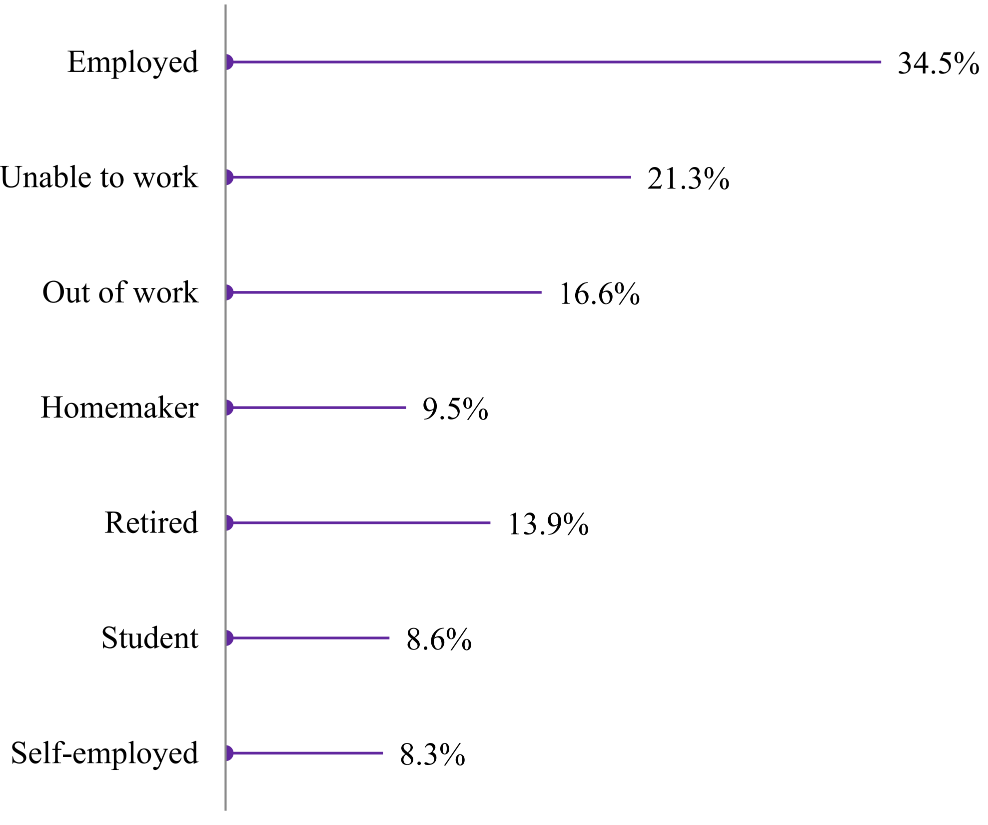
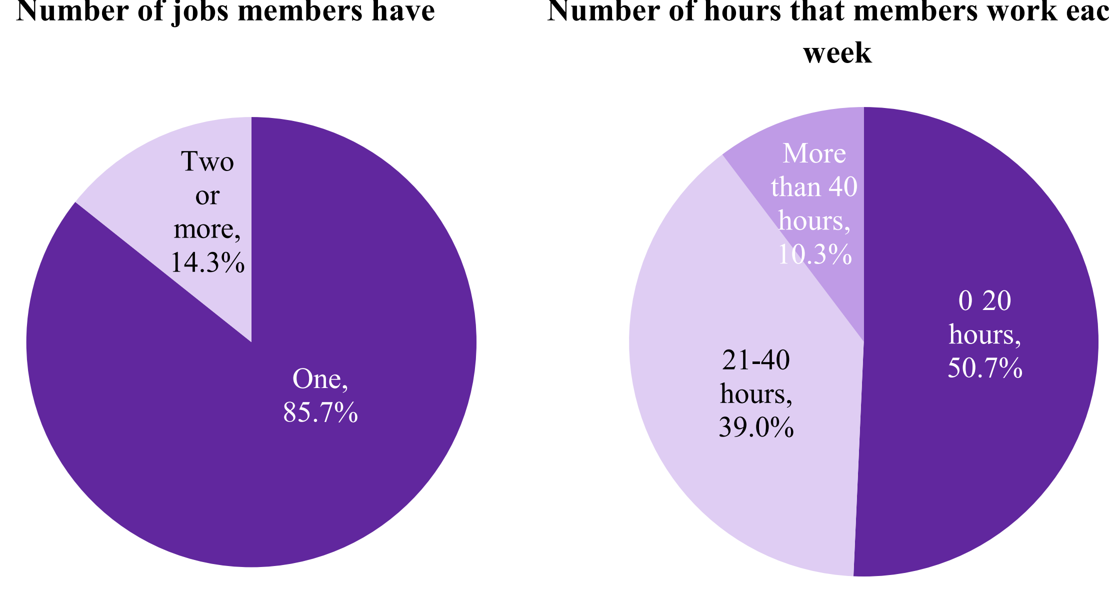



**Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]**




[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)**

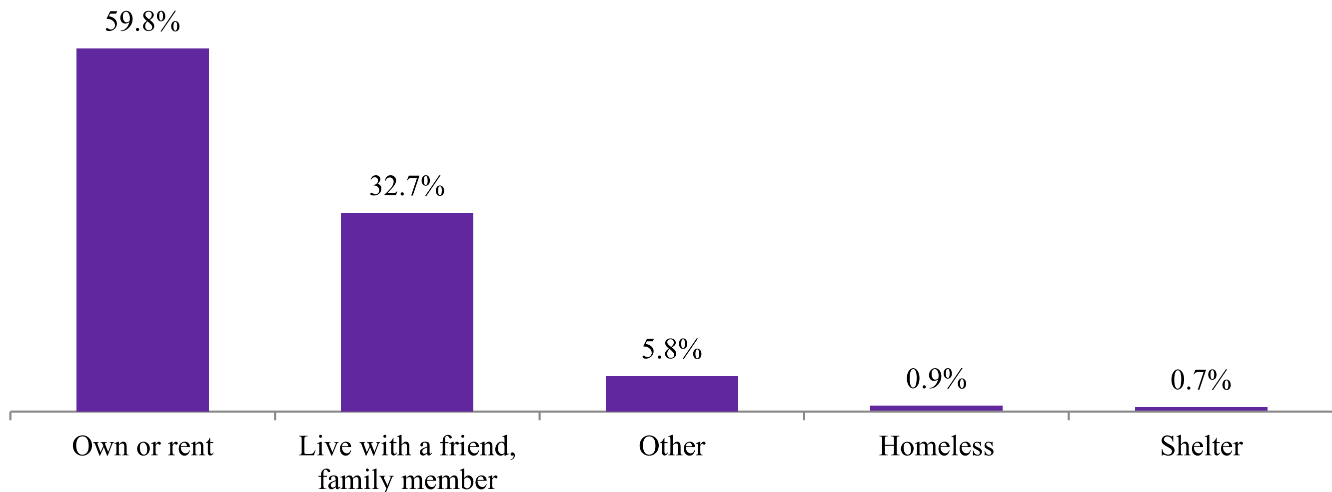
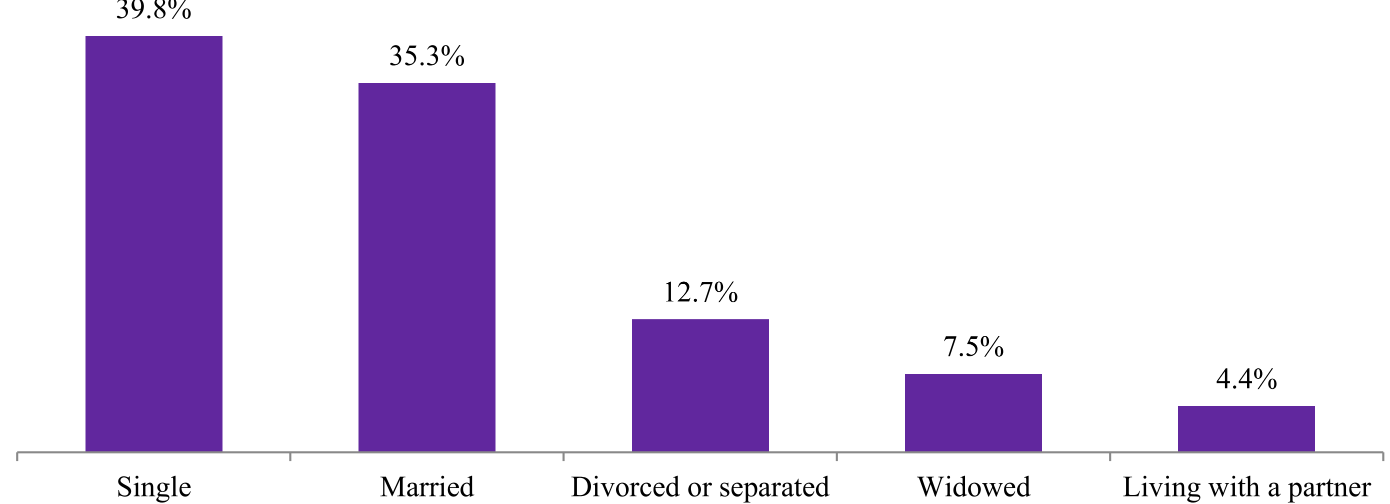



**Exhibit 49. Marital status of members (n=3,271)[30]**




[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)**

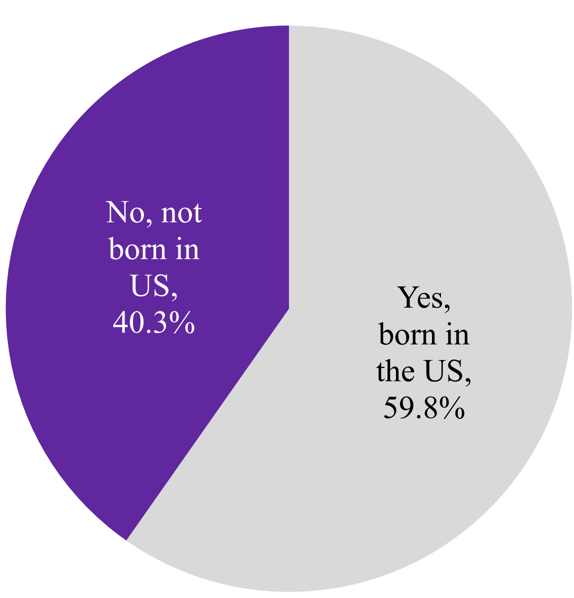
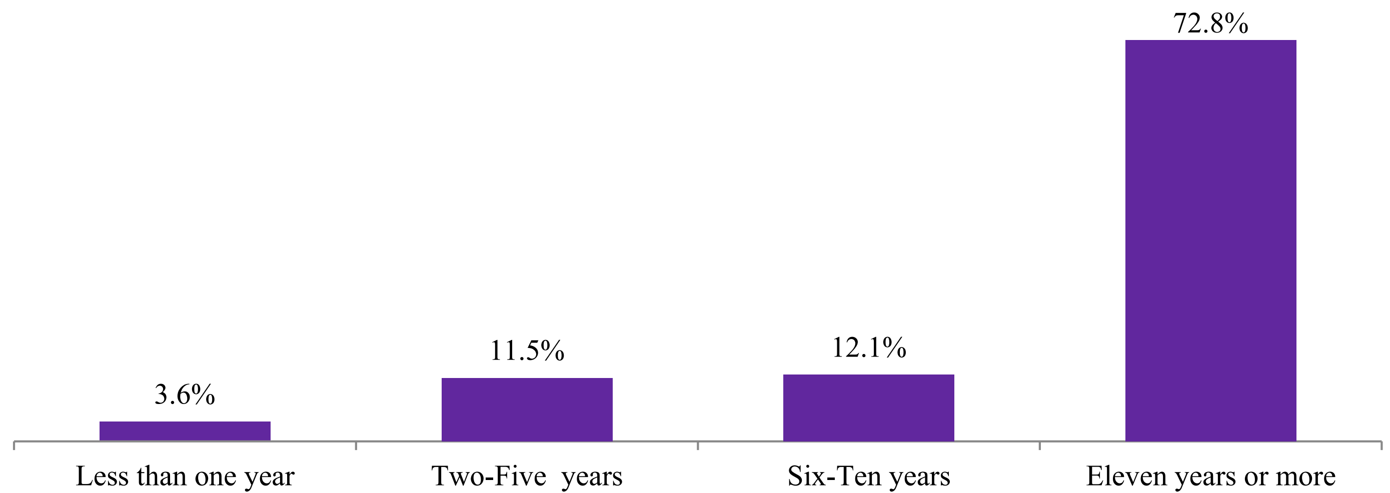



**Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]**




[31] Of those who were born outside of the U.S.

# Health Behaviors

**Exhibit 52. When members last saw a dentist (n=5,685)**

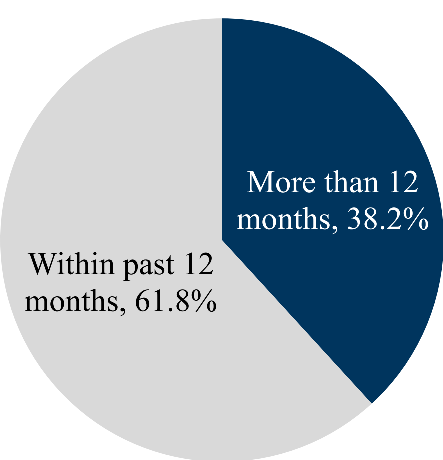
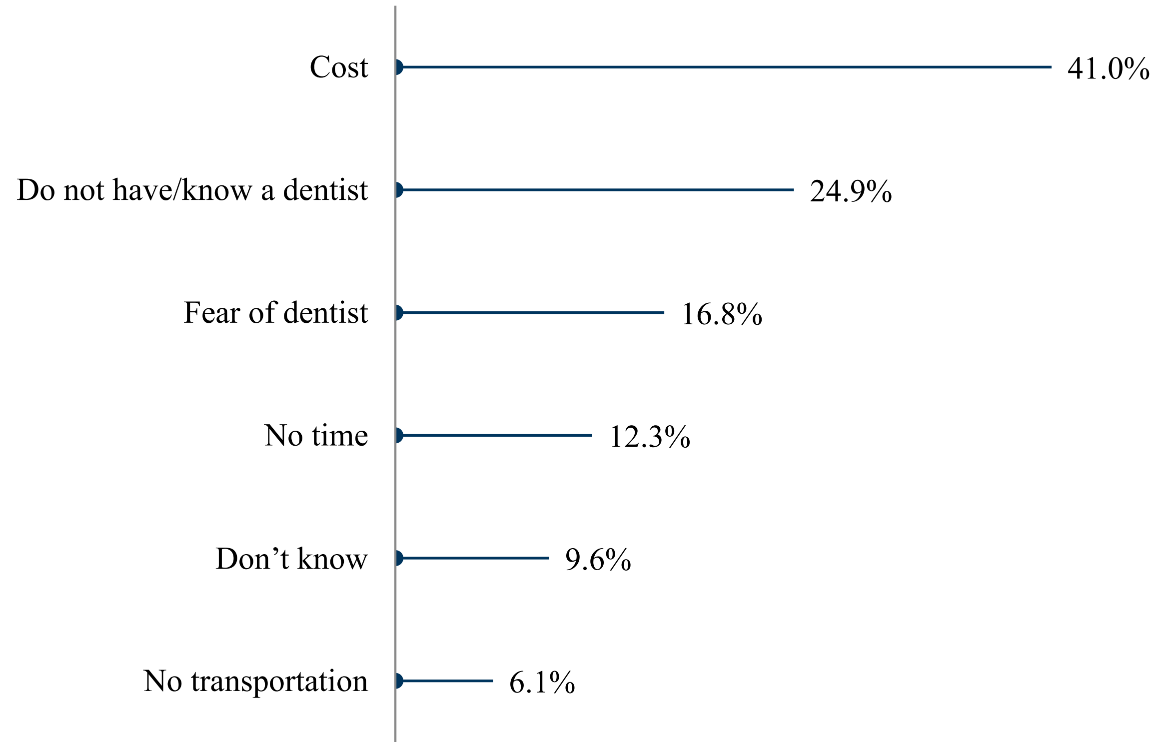


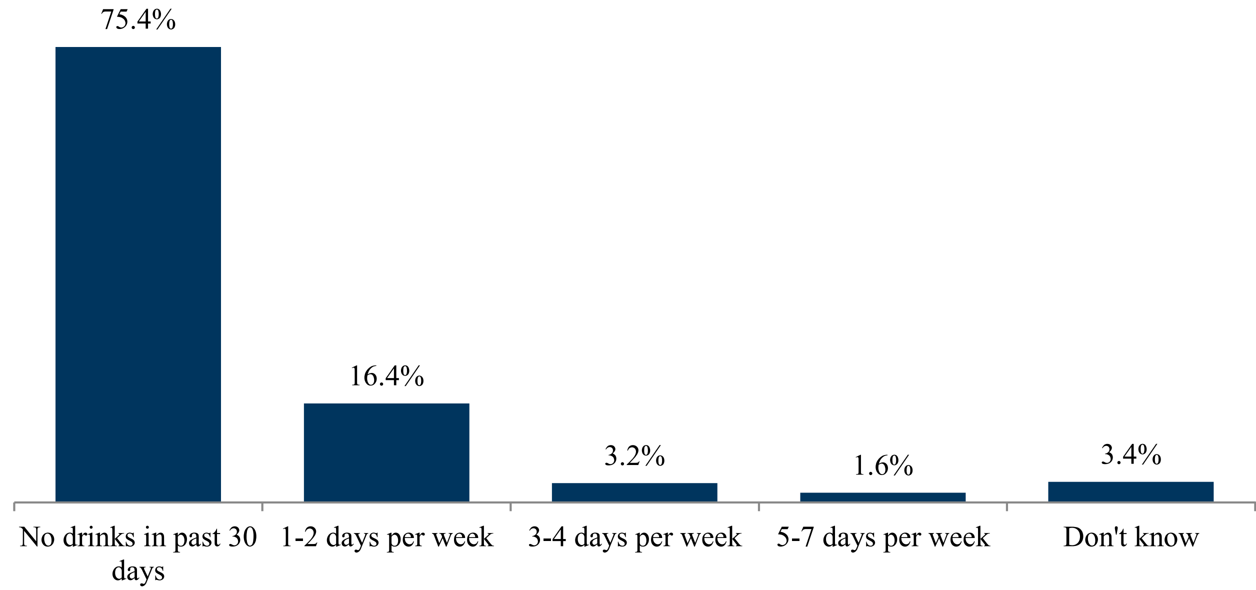

**Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]**




[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** |

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* — *11/28/2018*

**Authorized Signature** — **Date**

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# 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

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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**

# 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

# 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

| 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.<br><br>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.<br><br>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 CountyXXXXXXXX |
| 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 |

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.<br><br>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.<br>2. 16 new schools listed in Attachment G<br>3. 40 new schools not listed on Attachment G<br>4. 56 total new schools screened<br>5. Screenings from Expansion into New Schools: 7,468<br>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.<br><br>We are collecting data on all schools | 1. # of school events: 525<br>2. # of schools visited: 180<br>3. Children educated: 98,202 | Jun 2015 – May 2017 |

| schools | screened within the year though some related services may fall outside of the year (education/care coordination). | 4. Parents/Teachers Educated: 4,694<br>5. Screenings: 29,753<br>6. Fluoride: 27,018 (90.8%)<br>7. Children Receiving Sealants: 10,470 (35.2%)<br>8. # of Sealants Applied: 31,698<br>9. # of children screened with visible decay: 16,125 or 54.2%<br>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%<br>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 |

|  | 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.<br><br>Since there is a significant time lag in gathering this information, it will not be complete for reporting on quarterly reports.<br><br>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)<br>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) |  |
|---|---|---|---|

| 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:<br><br>a) Name and address of the school<br><br>b) Main contact person at the school who can verify that services were rendered<br><br>c) Total number of students enrolled at the school and the percentage of students who received dental services<br><br>d) Age range of children served (e.g. 5-11 years) at each school<br><br>e) Number and percentage of children served who had visible decay<br><br>f) Number of referrals for restorative care | See attached spreadsheet |

| 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. |

| | |
|---|---|
| 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. |

| 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 |

| 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 |

***<u>NOTE</u>*-*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.***

| 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.<br><br>(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: | [illegible] |
| Date: | June 30, 2017 |

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 & | 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 |
| 9/8/16 & 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 | | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3/20,21,23, 30,31/2017; 4/3,4,20/2017 | 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, & | 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 |
| 5/18,19,23 & 26/2017 | GG | 4 | Sunnyside Elementary | 9972 E. Russell Ave. | Garden Grove, CA | 92844 | CUR | 665 | 227 | | 199 | 74 | 219 | 32.6% | 5-12 | 101 | 44.5% | 21 | 683 | 8 | 5 | 2 | 2 | 1 | | | |
| 12/1/16 & 1/5/17 | TU | 6 | Thorman Elementary | 1402 Sycamore Ave. | Tustin, CA | 92780 | CUR | 573 | 281 | | 263 | 105 | 298 | 37.4% | 5-12 | 179 | 63.7% | 39 | 601 | 71 | 44 | 15 | 28 | 7 | 13 | 3 | 5 |
| 12/13/2016 | TU | 2 | Tustin Ranch Elementary | 12950 Robinson Dr. | Tustin, CA | 92782 | CUR | 646 | 150 | | 132 | 19 | 71 | 12.7% | 5-12 | 63 | 42.0% | 11 | 638 | 88 | 10 | 4 | 14 | | 3 | | |
| 12/8/16 & 1/30/17 | TU | 4 | Veeh Elementary | 300 South C St. | Tustin, CA | 92780 | CUR | 432 | 170 | | 164 | 63 | 181 | 37.1% | 5-12 | 103 | 60.6% | 17 | 451 | 58 | 21 | 9 | 24 | 2 | 3 | 2 | 2 |
| 4/3,4,25, & 27/2017 | GG | 4 | Violette Elementary | 12091 Lampson Ave. | Garden Grove, CA | 92840 | CUR | 500 | 224 | | 209 | 102 | 262 | 45.5% | 5-12 | 125 | 55.8% | 15 | 504 | 93 | 49 | 3 | 31 | 5 | 18 | | 2 |
| 10/4/2016 | GG | 2 | Wakeham Elementary | 7772 Chapman Ave. | Garden Grove, CA | 92840 | CUR | 344 | 100 | | 79 | 33 | 110 | 33.0% | 5-12 | 85 | 85.0% | 22 | 343 | 43 | 38 | 6 | 9 | 2 | 3 | 2 | 1 |
| 12/6/16 & 1/10/17 | MA | 4 | Walter Elementary | 10802 Rustic Lane | Anaheim, CA | 92804 | CUR | 624 | 161 | | 144 | 47 | 125 | 29.2% | 5-12 | 105 | 65.2% | 15 | 658 | 70 | 24 | 2 | 11 | 5 | 7 | 1 | |
| 3/2,6,7 & 4/3/17 | GG | 5 | Warren Elementary | 12871 Estock Dr. | Garden Grove, CA | 92840 | CUR | 488 | 212 | | 203 | 99 | 270 | 46.7% | 5-12 | 111 | 52.4% | 18 | 530 | 72 | 154 | 3 | 36 | 2 | 27 | | |
| 5/25,26 & 30/2017 | SA | 3 | Washington Elementary | 910 W. Anahurst Pl. | Santa Ana, CA | 92704 | NEW | 823 | 153 | 153 | 128 | 58 | 174 | 37.9% | 5-12 | 84 | 54.9% | 12 | 825 | | | | | | | | |
| 6/3/2016 | NM | 3 | Wilson Elementary | 801 W. Wilson St. | Costa Mesa, CA | 92627 | NEW | 477 | 111 | 111 | 100 | 67 | 176 | 60.4% | 5-12 | 12 | 10.8% | 10 | 486 | 32 | 36 | 4 | 18 | 3 | 16 | 4 | 1 |
| 6/9/2016 | SA | 4 | Wilson Elementary | 1317 N. Baker St. | Santa Ana, CA | 92706 | CUR | 720 | 294 | | 266 | 133 | 266 | 45.2% | 5-12 | 150 | 51.0% | 33 | 749 | 88 | 73 | 8 | 39 | 4 | 16 | 14 | 1 |
| 1/26/2017 | GG | 2 | Woodbury Elementary | 11362 Woodbury Rd. | Garden Grove, CA | 92843 | CUR | 410 | 92 | | 84 | 26 | 68 | 28.3% | 5-12 | 41 | 44.6% | 5 | 440 | 64 | 17 | 2 | 23 | 3 | 5 | | |

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3/12,27,30/ 2017 | GG | 3 | Woodbury Elementary | 11362 Woodbury Rd. | Garden Grove, CA | 92843 | CUR | 410 | 94 | | 88 | 67 | 198 | 71.3% | 5-12 | 41 | 43.6% | 14 | | | | | | | | | |
| | | ## | | | | | | 108,211 | 29,753 | 7,468 | 27,018 | 10,470 | 31,698 | 27.5% | | 16,125 | 54.2% | 3,028 | 102,896 | 9,873 | 6,286 | 953 | 3,151 | 543 | 1,575 | 560 | 245 |
| | | ## | | | | | | | 27.5% | 25.1% | 90.8% | 35.2% | | | | 54.2% | | 10.2% | | 33.2% | 39.0% | 5.9% | 19.5% | 3.4% | 9.8% | 3.5% | 1.5% |
| | | | | | | | | | | | | | | | | | | | | 5,351 | | | 29.2% | 5.0% | 14.6% | 5.2% | 2.3% |
| | | | | | | | | | | | | | | | | | | | | 10,774 | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | 24.5% | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | 13.1% | |

| | | | |
|---|---|---|---|
| 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 |

# Board of Directors Meeting
# September 5, 2019

## Provider Advisory Committee (PAC) Update

**August 8, 2019 PAC Meeting**

PAC members welcomed John Kelly, M.D., as the Physician Representative and Loc Tran, Pharm.D., as the Pharmacy representative. PAC members also acknowledged the passing of Dr. Theodore Caliendo, a long serving PAC member, and the resignation of Allied Health Representative Dr Brian Lee.

The PAC also reviewed a recommendation for a Long-Term Services and Support Representative and made the decision to extend the recruitment to solicit additional applicants.

Michael Schrader, Chief Executive Officer, notified the PAC that on August 9, 2019, the Board would be holding a public Strategic Planning Session beginning at 10:00 A.M. in Room 109-N at CalOptima's offices, and that members of the public are welcome to attend.

Ladan Khamseh, Chief Operating Officer, provided updates on the Whole-Child Model implementation that began on July 1, 2019. Ms. Khamseh thanked all the providers for helping to ensure a smooth transition. Several of the committee members offered their insights on the process of enrolling newborn babies into the program.

David Ramirez, M.D., Chief Medical Officer, notified the PAC that the Board had allocated more funds for additional mobile clinics to assist the Homeless Health Initiative. PAC also received management updates from Nancy Huang, Interim CFO, and Michelle Laughlin, Executive Director, Network Operations.

The PAC also received staff presentations on the Health Homes Program, a demonstration of the new CalOptima website and a Federal and State Legislative update.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.

**Board of Directors Meeting**
**September 5, 2019**

**Member Advisory Committee (MAC) Update**

**<u>August 8, 2019 MAC Meeting</u>**

MAC Committee Members reviewed the FY 2019-2020 slate of candidates for the Chair and Vice Chair of the MAC. The committee recommends Christine Tolbert for Chair and Pamela Pimentel for Vice Chair.

Michael Schrader, Chief Executive Officer, discussed the special meeting of the Board of Directors being held on August 9, 2019.

Ladan Khamseh, Chief Operating Officer, discussed the Whole Child Model program transition to CalOptima effective July 1, 2019.

In addition to the Chief Medical Officer update from David Ramirez, M.D., MAC received reports on the Health Homes Program, Annual Healthcare Effectiveness Data and Information Set (HEDIS) report, a Health Network Report Card for Members update, and a Provider Overcapacity Notification presentation from CalOptima staff. MAC members also received a demonstration of the new CalOptima website and a Federal and State Legislative update.

MAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the MAC's current activities.

# CALOPTIMA
# BOARD OF DIRECTORS
# MODELS TO MOTIVATE NETWORK OUTCOMES
## SEPTEMBER 5, 2019

Prepared by Pacific Health Consulting Group and Milliman
August 2019

# Meeting Agenda



- Introductions
- Network Model Types Review
- Reimbursement Options and Use
- CalOptima Networks
- Next Session

- **Today's Goal**
  - **Understanding network reimbursement models use as a method to impact provider behavior**

# Introductions
# Pacific Health Consulting Group

**Bobbie Wunsch**
**Founder and Partner**

**Tim Reilly**
**Founder and Partner**

# Network Model Types Review



- Nationally, and in California, most types of Networks can be categorized in the following groups:

- Direct Contracted-Contracts with individual providers. Delivery system organized by health plan. Individual Physicians or Physician Groups are typically paid Fee For Service (FFS) and the health plan organizes a system around them.

- Partially Delegated-Contracts with entities that organize part of the delivery system and are delegated a wide scope of professional benefits and administrative functions. Capitation is usually the main reimbursement method for the entity. Typical entities are IPAs and Medical groups.

- Fully Delegated-Contracts with entities that organize a complete delivery system and are delegated a full scope of benefits and administrative functions. These entities are paid capitation. ACOs, PHCs, Dual Capitated Hospitals and Physician Groups, and other HMOs are typical participants.

# Reimbursement Options and Use

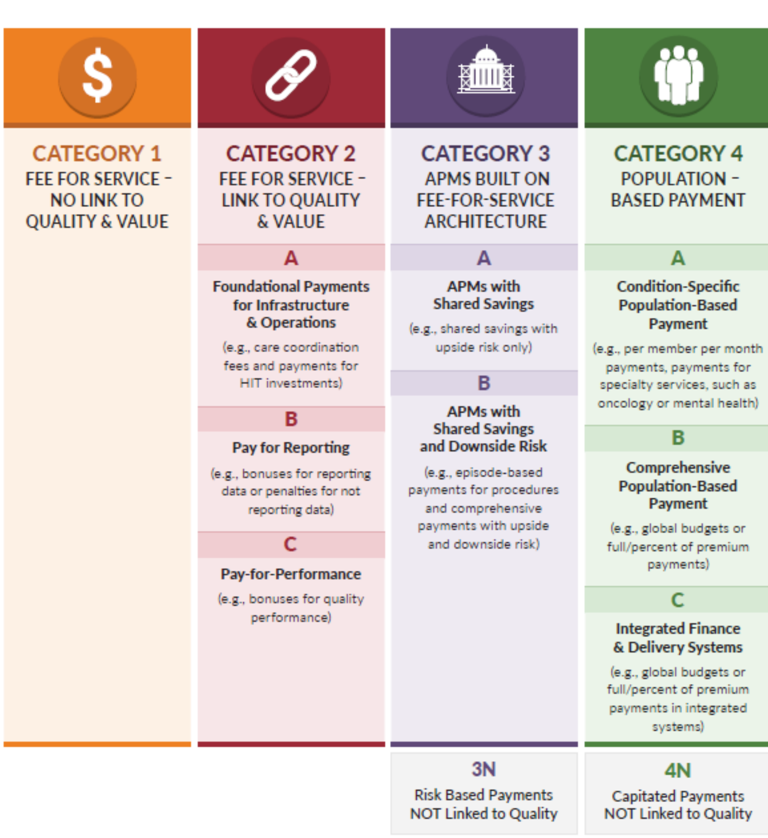


- **Fee-for-Service (FFS):** Payment set by procedure code fee schedule. Incentivizes volume of services.
- **Bundled Payment:** Payment based on the estimated cost of all services for a problem, e.g. knee replacement. Incentivizes efficiency and quality of care to avoid the costs of complications or readmission.
- **Pay for Performance (P4P):** Payment base on provider's performance on agreed quality measures, e.g. readmission rates.
- **Shared Savings:** Only up-side risk, rewarded but not required to cover deficits
- **Shared Risk:**
  - **Up-side Risk:** Aligned incentives to realize and share savings achieved through quality care impacting cost and utilization.
  - **Down-side Risk:** Aligned risk to share excess costs due to over-budget utilization and costs. Incentivizes quality of care, coordination of services, and holistic care.
- **Capitation:** Providers are paid a set amount for each member for a period of time, e.g. per member per month. The set amount is paid regardless of whether the member seeks care or not.

# National Network Model Categorization



- Covers a continuum of clinical outcomes and financial risk for providers with fully integrated care
- Provides a standard approach to categorize payment methodologies
- Moves along a continuum from no risk/no quality requirements to Alternative Payment Models (APM) with increasing financial and performance quality risk sharing

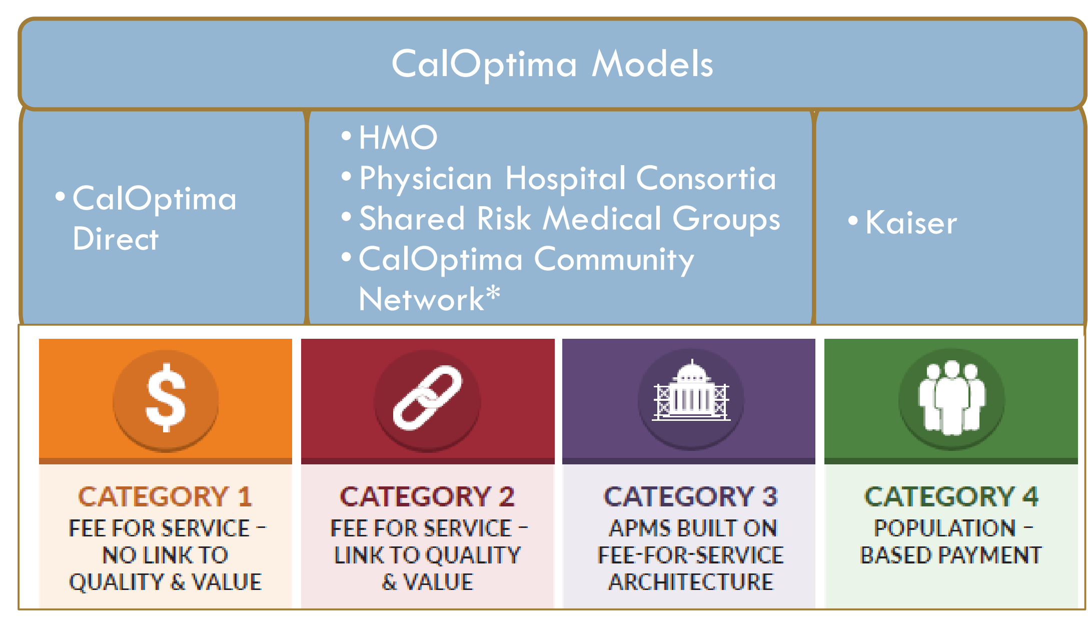



Source: Health Care Payment Learning & Action Network. *Alternative Payment Models Framework*. July 11, 2017. https://hcp-lan.org/

# CalOptima Network Models



- Each model has advantages and disadvantages
- Variety of options provides flexibility
- Models match member and provider needs

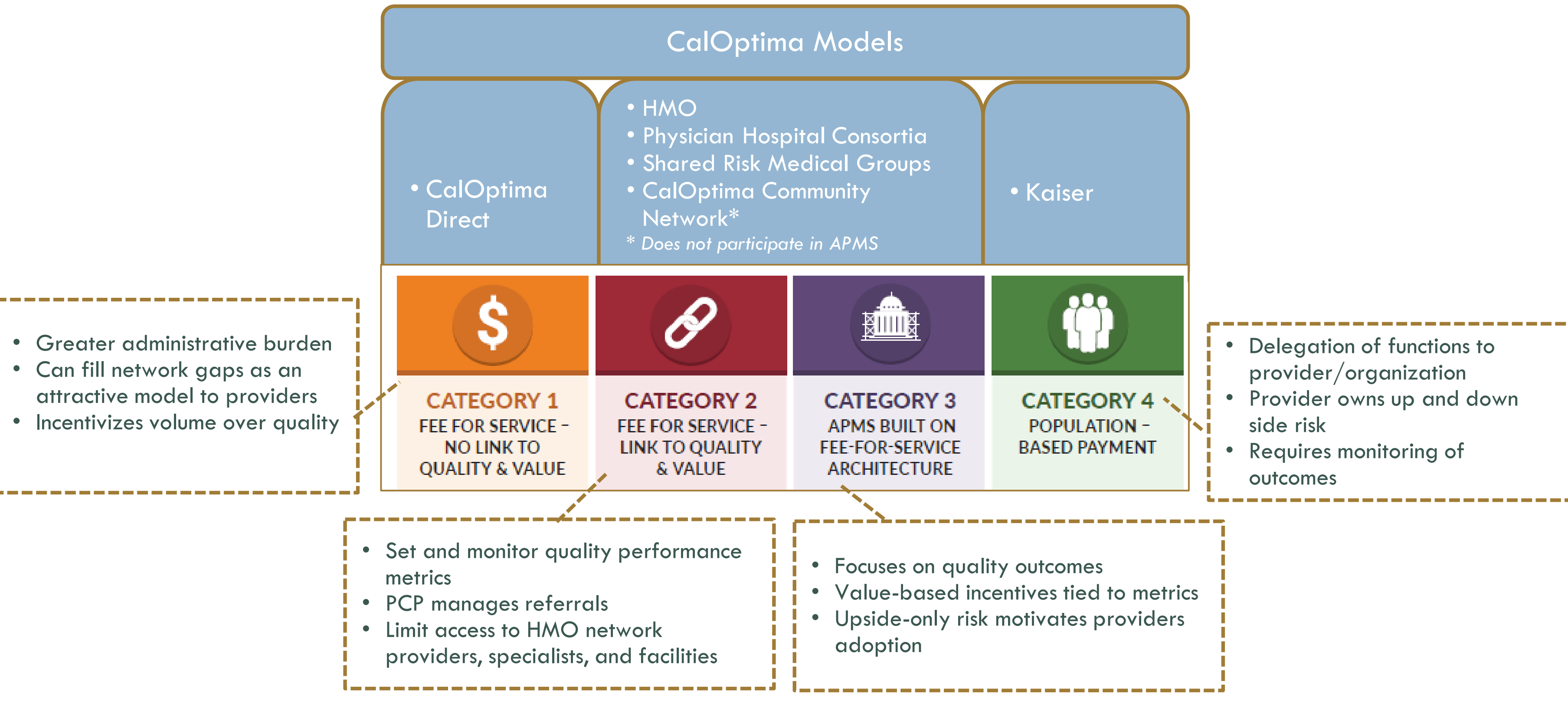



** Does not participate in APMS*

*CalOptima uses different models to serve members*

# CalOptima Network Models Attributes






Source: Health Care Payment Learning & Action Network. *Alternative Payment Models Framework*. July 11, 2017. https://hcp-lan.org/

# Incentive Types, Funding, and Impact



| Incentive | Funding Options | Anticipated Impact |
|---|---|---|
| Bonuses | Withhold/premium allocation | Bonus linked to quality outcomes can impact provider behavior by focusing on outcomes |
| Shared savings | Reduced costs and utilization (most California risk pools fall into this category) | Focus on quality and coordination of care to reduce readmissions and complications |
| Shared risk | Providers share downside when costs exceed the rate (limited in California) | Providers focus on quality to realize optimal care outcomes which impact costs |
| Pay for Performance | Funded through savings realized by achieving performance goals, e.g. reduced readmissions | Reaching thresholds realizes aligned goals for quality of care and reduced costs |

# California Landscape



- Directed payment, e.g. Prop. 56, that mandates that the plan is required to pay providers a supplementary amount so that MediCal will exceed Medicare
  - Goal is for increased quality and other performance targets
  - Plan statutorily required to complete, not delegates
- Various approaches to incentive payment method
  - Direct to providers, which allows tailoring for providers
  - Through delegated networks using contracted expectations
  - Independent of delegated networks
- IEHP – no consistent risk sharing methodology
- LA Care – shared savings without required pay back for deficits (adjusted in carry forward to next year)

# Roadmap



- Decide **what** CalOptima wants to accomplish
- Determine **how** to best realize the identified goals
  - Which network models
  - What payment mechanisms
  - Who will manage which components, plan or delegates
- Decide **how** to design network models and payment then structure contracts to align with meeting objectives

## Next Session



- September 12 - Attend Provider Advisory Committee
- November 7, 2019 - Final Project Presentation

# Financial Summary

## July 2019

**Board of Directors Meeting**

**September 5, 2019**

**Nancy Huang**

**Interim Chief Financial Officer**

# FY 2019-20: Consolidated Enrollment

## July 2019 MTD

Overall enrollment was 755,893 members

- Actual higher than budget 3,071 members or 0.4%
  - Medi-Cal favorable variance of 3,000 members
    - Temporary Assistance for Needy Families (TANF) favorable variance of 4,253 members
    - Seniors and Persons with Disabilities (SPD) favorable variance of 1,059 members
    - Medi-Cal Expansion (MCE) unfavorable variance of 1,168 members
    - Whole Child Model (WCM) unfavorable variance of 1,115
    - Long-Term Care (LTC) unfavorable variance of 29
  - OneCare Connect favorable variance of 41 members
- 4,030 decrease from June
  - Medi-Cal decrease of 4,165 members
  - OneCare Connect increase of 134 members
  - OneCare decrease of 7 members
  - PACE increase of 8 members

# FY 2019-20: Consolidated Revenues

## July 2019 MTD

- Actual higher than budget $2.0 million or 0.7%
  - Medi-Cal favorable to budget $0.7 million or 0.3%
    - Favorable volume variance of $1.1 million
    - Unfavorable price variance of $0.4 million
  - OneCare Connect favorable to budget $1.1 million or 4.6%
    - Favorable volume variance of $0.1 million
    - Favorable price variance of $1.0 million
  - OneCare favorable to budget $243.7 thousand or 15.5%
    - Favorable volume variance of $37.9 thousand
    - Favorable price variance of $205.8 thousand
  - PACE unfavorable to budget $13.9 thousand or 0.5%
    - Unfavorable volume variance of $46.7 thousand
    - Favorable price variance of $32.8 thousand

# FY 2019-20: Consolidated Medical Expenses

## July 2019 MTD

- Actual higher than budget $7.5 million or 2.7%
  - Medi-Cal unfavorable variance of $7.0 million or 2.7%
    - Unfavorable volume variance of $1.0 million
    - Unfavorable price variance of $6.0 million
      - Prescription Drug expenses unfavorable variance of $7.5 million due to high utilization
      - Professional Claims expenses unfavorable variance of $2.7 million due to Proposition 56 claims and Incurred But Not Reported (IBNR) claims
      - Reinsurance and Other expenses favorable variance of $2.0 million due to budgeting of homeless health initiatives
      - Medical Management expenses favorable variance of $1.2 million
    - Due to claim lag and limited information available, most of WCM medical expenses were estimated based on budget assumptions in July 2019

# FY 2019-20: Consolidated Medical Expenses (cont.)

## July 2019 MTD

- OneCare Connect unfavorable variance of $0.6 million or 2.7%
  - Unfavorable volume variance of $0.1 million
  - Unfavorable price variance of $0.6 million
- OneCare favorable variance of $176.8 thousand or 11.1%
  - Unfavorable volume variance of $38.5 thousand
  - Favorable price variance of $215.4 thousand
- PACE unfavorable variance of $53.1 thousand or 2.2%
  - Favorable volume variance of $42.2 thousand
  - Unfavorable price variance of $95.4 thousand

## Medical Loss Ratio (MLR)

- July 2019 MTD: Actual: 97.4% Budget: 95.6%

# FY 2019-20: Consolidated Administrative Expenses

## July 2019 MTD

- Actual lower than budget $2.0 million or 14.7%
  - Salaries, wages and benefits: favorable variance of $0.6 million
  - Other categories: favorable variance of $1.4 million

## Administrative Loss Ratio (ALR)

- July 2019 MTD: Actual: 3.8% Budget: 4.5%

# FY 2019-20: Change in Net Assets

## July 2019 MTD

- ($2.0) million change in net assets
- $3.1 million unfavorable to budget
  - ➢Higher than budgeted revenue of $2.0 million
  - ➢Higher than budgeted medical expenses of $7.6 million
  - ➢Lower than budgeted administrative expenses of $2.0 million
  - ➢Higher than budgeted investment and other income of $0.5 million

# Enrollment Summary:
# July 2019

| Month-to-Date | | | | | Year-to-Date | | | |
|---|---|---|---|---|---|---|---|---|
| **Actual** | **Budget** | **Variance** | **%** | **Enrollment (By Aid Category)** | **Actual** | **Budget** | **Variance** | **%** |
| 65,252 | 65,188 | 64 | 0.1% | Aged | 65,252 | 65,188 | 64 | 0.1% |
| 566 | 615 | (49) | (8.0%) | BCCTP | 566 | 615 | (49) | (8.0%) |
| 44,910 | 43,866 | 1,044 | 2.4% | Disabled | 44,910 | 43,866 | 1,044 | 2.4% |
| 291,573 | 287,607 | 3,966 | 1.4% | TANF Child | 291,573 | 287,607 | 3,966 | 1.4% |
| 88,396 | 88,109 | 287 | 0.3% | TANF Adult | 88,396 | 88,109 | 287 | 0.3% |
| 3,375 | 3,404 | (29) | (0.9%) | LTC | 3,375 | 3,404 | (29) | (0.9%) |
| 233,874 | 235,042 | (1,168) | (0.5%) | MCE | 233,874 | 235,042 | (1,168) | (0.5%) |
| 11,825 | 12,940 | (1,115) | (8.6%) | WCM | 11,825 | 12,940 | (1,115) | (8.6%) |
| **739,771** | **736,771** | **3,000** | **0.4%** | **Medi-Cal** | **739,771** | **736,771** | **3,000** | **0.4%** |
| **14,257** | **14,216** | **41** | **0.3%** | **OneCare Connect** | **14,257** | **14,216** | **41** | **0.3%** |
| **1,530** | **1,494** | **36** | **2.4%** | **OneCare** | **1,530** | **1,494** | **36** | **2.4%** |
| **335** | **341** | **(6)** | **(1.8%)** | **PACE** | **335** | **341** | **(6)** | **(1.8%)** |
| **755,893** | **752,822** | **3,071** | **0.4%** | **CalOptima Total** | **755,893** | **752,822** | **3,071** | **0.4%** |

# Financial Highlights: July 2019

| Month-to-Date | | | | | Year-to-Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Budget | % Budget | | Actual | Budget | $ Budget | % Budget |
| 755,893 | 752,822 | 3,071 | 0.4% | Member Months | 755,893 | 752,822 | 3,071 | 0.4% |
| 299,570,627 | 297,529,501 | 2,041,127 | 0.7% | Revenues | 299,570,627 | 297,529,501 | 2,041,127 | 0.7% |
| 291,931,203 | 284,383,353 | (7,547,851) | (2.7%) | Medical Expenses | 291,931,203 | 284,383,353 | (7,547,851) | (2.7%) |
| 11,357,403 | 13,313,535 | 1,956,132 | 14.7% | Administrative Expenses | 11,357,403 | 13,313,535 | 1,956,132 | 14.7% |
| **(3,717,979)** | **(167,387)** | **(3,550,593)** | **(2121.2%)** | **Operating Margin** | **(3,717,979)** | **(167,387)** | **(3,550,593)** | **(2121.2%)** |
| 1,747,798 | 1,250,000 | 497,798 | 39.8% | Non Operating Income (Loss) | 1,747,798 | 1,250,000 | 497,798 | 39.8% |
| **(1,970,181)** | **1,082,613** | **(3,052,794)** | **(282.0%)** | **Change in Net Assets** | **(1,970,181)** | **1,082,613** | **(3,052,794)** | **(282.0%)** |
| 97.4% | 95.6% | (1.9%) | | Medical Loss Ratio | 97.4% | 95.6% | (1.9%) | |
| 3.8% | 4.5% | 0.7% | | Administrative Loss Ratio | 3.8% | 4.5% | 0.7% | |
| (1.2%) | (0.1%) | (1.2%) | | Operating Margin Ratio | (1.2%) | (0.1%) | (1.2%) | |
| 100.0% | 100.0% | | | Total Operating | 100.0% | 100.0% | | |

# Consolidated Performance Actual vs. Budget: July 2019 (in millions)

| MONTH-TO-DATE | | | | YEAR-TO-DATE | | |
|---|---|---|---|---|---|---|
| Actual | Budget | Variance | | Actual | Budget | Variance |
| (3.2) | 1.6 | (4.8) | Medi-Cal | (3.2) | 1.6 | (4.8) |
| (0.9) | (1.6) | 0.8 | OCC | (0.9) | (1.6) | 0.8 |
| 0.3 | (0.2) | 0.5 | OneCare | 0.3 | (0.2) | 0.5 |
| 0.0 | 0.1 | (0.1) | PACE | 0.0 | 0.1 | (0.1) |
| **(3.7)** | **(0.2)** | **(3.6)** | **Operating** | **(3.7)** | **(0.2)** | **(3.6)** |
| 1.7 | 1.3 | 0.5 | Inv./Rental Inc, MCO tax | 1.7 | 1.3 | 0.5 |
| **1.7** | **1.3** | **0.5** | **Non-Operating** | **1.7** | **1.3** | **0.5** |
| **(2.0)** | **1.1** | **(3.1)** | **TOTAL** | **(2.0)** | **1.1** | **(3.1)** |

# Consolidated Revenue & Expense: July 2019 MTD

| | Medi-Cal Classic | Medi-Cal Expansion | Whole Child Model | Total Medi-Cal | OneCare Connect | OneCare | PACE | Consolidated |
|---|---|---|---|---|---|---|---|---|
| **MEMBER MONTHS** | 494,072 | 233,874 | 11,825 | 739,771 | 14,257 | 1,530 | 335 | 755,893 |
| **REVENUES** | | | | | | | | |
| Capitation Revenue | $ 143,553,009 | $ 103,663,269 | $ 23,142,951 | $ 270,359,229 | $ 24,752,077 | $ 1,818,209 | $ 2,641,112 | $ 299,570,627 |
| Other Income | - | - | | - | - | - | - | - |
| **Total Operating Revenue** | 143,553,009 | 103,663,269 | 23,142,951 | 270,359,229 | 24,752,077 | 1,818,209 | 2,641,112 | 299,570,627 |
| **MEDICAL EXPENSES** | | | | | | | | |
| Provider Capitation | 38,747,620 | 44,463,058 | 10,217,936 | 93,428,614 | 11,289,150 | 482,924 | | 105,200,688 |
| Facilities | 23,667,106 | 22,340,652 | 3,238,731 | 49,246,488 | 3,271,773 | 319,074 | 1,059,579 | 53,896,914 |
| Ancillary | - | - | | - | 727,111 | 71,901 | - | 799,012 |
| Professional Claims | 16,402,774 | 8,361,501 | 1,194,820 | 25,959,094 | - | - | 420,333 | 26,379,427 |
| Prescription Drugs | 29,047,231 | 22,320,842 | 566,219 | 51,934,292 | 5,716,226 | 494,170 | 214,473 | 58,359,160 |
| MLTSS | 26,905,350 | 2,791,074 | 7,658,945 | 37,355,369 | 1,503,480 | (2,476) | 25,654 | 38,882,027 |
| Medical Management | 2,027,447 | 1,014,719 | 391,185 | 3,433,351 | 1,150,294 | 56,929 | 649,949 | 5,290,522 |
| Quality Incentives | 918,519 | 472,735 | | 1,391,254 | 274,200 | | 4,549 | 1,670,003 |
| Reinsurance & Other | 667,267 | 548,593 | 8,973 | 1,224,832 | 149,781 | | 78,837 | 1,453,450 |
| **Total Medical Expenses** | 138,383,312 | 102,313,174 | 23,276,808 | 263,973,294 | 24,082,014 | 1,422,522 | 2,453,374 | 291,931,203 |
| **Medical Loss Ratio** | 97.0% | 98.7% | 100.6% | 97.6% | 97.3% | 78.2% | 92.9% | 97.4% |
| **GROSS MARGIN** | **5,169,697** | **1,350,096** | **(133,857)** | **6,385,935** | **670,063** | **395,688** | **187,738** | **7,639,424** |
| **ADMINISTRATIVE EXPENSES** | | | | | | | | |
| Salaries & Benefits | | | | 6,919,237 | 774,127 | 35,209 | 156,645 | 7,885,217 |
| Professional fees | | | | 91,947 | (850) | | | 91,097 |
| Purchased services | | | | 834,160 | 157,088 | 16,760 | 21,202 | 1,029,209 |
| Printing & Postage | | | | 317,141 | 50,085 | (8,879) | 719 | 359,067 |
| Depreciation & Amortization | | | | 401,259 | | | 2,092 | 403,351 |
| Other expenses | | | | 1,152,693 | 37,129 | | 2,412 | 1,192,233 |
| Indirect cost allocation & Occupancy | | | | (161,794) | 519,792 | 35,589 | 3,642 | 397,229 |
| **Total Administrative Expenses** | | | | 9,554,642 | 1,537,371 | 78,679 | 186,712 | 11,357,403 |
| **Admin Loss Ratio** | | | | 3.5% | 6.2% | 4.3% | 7.1% | 3.8% |
| **INCOME (LOSS) FROM OPERATIONS** | | | | (3,168,706) | (867,308) | 317,009 | 1,026 | (3,717,979) |
| **INVESTMENT INCOME** | | | | | | | | 1,747,798 |
| **CHANGE IN NET ASSETS** | | | | **$ (3,168,706)** | **$ (867,308)** | **$ 317,009** | **$ 1,026** | **$ (1,970,181)** |
| **BUDGETED CHANGE IN NET ASSETS** | | | | 1,585,417 | (1,643,841) | (174,627) | 65,664 | 1,082,613 |
| **VARIANCE TO BUDGET - FAV (UNFAV)** | | | | $ (4,754,124) | $ 776,533 | $ 491,636 | $ (64,638) | $ (3,052,794) |

# Balance Sheet:
# As of July 2019

| ASSETS | | LIABILITIES & NET POSITION | |
|---|---|---|---|
| Current Assets | | Current Liabilities | |
| Operating Cash | $294,005,950 | Accounts Payable | $8,195,445 |
| Investments | 589,942,289 | Medical Claims liability | 728,775,781 |
| Capitation receivable | 299,059,139 | Accrued Payroll Liabilities | 12,720,471 |
| Receivables - Other | 36,234,453 | Deferred Revenue | 39,917,963 |
| Prepaid expenses | 6,875,890 | Deferred Lease Obligations | 38,153 |
| | | Capitation and Withholds | 126,031,885 |
| **Total Current Assets** | **1,226,117,721** | **Total Current Liabilities** | **915,679,698** |
| Capital Assets | | | |
| Furniture & Equipment | 37,086,365 | | |
| Building/Leasehold Improvements | 7,090,283 | | |
| 505 City Parkway West | 50,464,989 | | |
| | 94,641,636 | | |
| Less: accumulated depreciation | (47,103,553) | | |
| Capital assets, net | 47,538,083 | Other (than pensions) post employment benefits liability | 24,825,940 |
| Other Assets | | Net Pension Liabilities | 23,732,883 |
| Restricted Deposit & Other | 300,000 | Bldg 505 Development Rights | - |
| Homeless Health Reserve | 60,000,000 | | |
| Board-designated assets: | | **TOTAL LIABILITIES** | **964,238,521** |
| Cash and Cash Equivalents | 13,335,635 | | |
| Long-term Investments | 546,836,157 | Deferred Inflows | |
| Total Board-designated Assets | 560,171,792 | Change in Assumptions | 7,250,505 |
| | | Excess Earnings | 156,330 |
| **Total Other Assets** | 620,471,792 | | |
| | | Net Position | |
| **TOTAL ASSETS** | **1,894,127,596** | TNE | 94,829,046 |
| | | Funds in Excess of TNE | 838,743,643 |
| Deferred Outflows | | **TOTAL NET POSITION** | 933,572,689 |
| Pension Contributions | 1,242,962 | | |
| Difference in Experience | 3,419,328 | | |
| Excess Earning | - | | |
| Changes in Assumptions | 6,428,159 | | |
| **TOTAL ASSETS & DEFERRED OUTFLOWS** | **1,905,218,045** | **TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION** | **1,905,218,045** |

# Board Designated Reserve and TNE Analysis
# As of July 2019

| Type | Reserve Name | Market Value | Benchmark | | Variance | |
|---|---|---|---|---|---|---|
| | | | Low | High | Mkt - Low | Mkt - High |
| | Tier 1 - Payden & Rygel | 153,459,393 | | | | |
| | Tier 1 - Logan Circle | 152,583,250 | | | | |
| | Tier 1 - Wells Capital | 152,692,768 | | | | |
| Board-designated Reserve | | | | | | |
| | | 458,735,412 | 304,878,980 | 476,182,420 | 153,856,432 | (17,447,008) |
| TNE Requirement | Tier 2 - Logan Circle | 101,436,380 | 94,829,046 | 94,829,046 | 6,607,334 | 6,607,334 |
| | **Consolidated:** | **560,171,792** | **399,708,026** | **571,011,466** | **160,463,766** | **(10,839,674)** |
| | *Current reserve level* | *1.96* | *1.40* | *2.00* | | |

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.

# UNAUDITED FINANCIAL STATEMENTS

## July 2019

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# CalOptima - Consolidated
## Financial Highlights
## For the One Month Ended July 31, 2019

| Month-to-Date | | | | | Year-to-Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Budget | % Budget | | Actual | Budget | $ Budget | % Budget |
| 755,893 | 752,822 | 3,071 | 0.4% | Member Months | 755,893 | 752,822 | 3,071 | 0.4% |
| 299,570,627 | 297,529,501 | 2,041,127 | 0.7% | Revenues | 299,570,627 | 297,529,501 | 2,041,127 | 0.7% |
| 291,931,203 | 284,383,353 | (7,547,851) | (2.7%) | Medical Expenses | 291,931,203 | 284,383,353 | (7,547,851) | (2.7%) |
| 11,357,403 | 13,313,535 | 1,956,132 | 14.7% | Administrative Expenses | 11,357,403 | 13,313,535 | 1,956,132 | 14.7% |
| **(3,717,979)** | **(167,387)** | **(3,550,593)** | **(2121.2%)** | **Operating Margin** | **(3,717,979)** | **(167,387)** | **(3,550,593)** | **(2121.2%)** |
| 1,747,798 | 1,250,000 | 497,798 | 39.8% | Non Operating Income (Loss) | 1,747,798 | 1,250,000 | 497,798 | 39.8% |
| **(1,970,181)** | **1,082,613** | **(3,052,794)** | **(282.0%)** | **Change in Net Assets** | **(1,970,181)** | **1,082,613** | **(3,052,794)** | **(282.0%)** |
| 97.4% | 95.6% | (1.9%) | | Medical Loss Ratio | 97.4% | 95.6% | (1.9%) | |
| 3.8% | 4.5% | 0.7% | | Administrative Loss Ratio | 3.8% | 4.5% | 0.7% | |
| (1.2%) | (0.1%) | (1.2%) | | Operating Margin Ratio | (1.2%) | (0.1%) | (1.2%) | |
| 100.0% | 100.0% | | | Total Operating | 100.0% | 100.0% | | |

# July 31, 2019 Unaudited Financial Statements

## SUMMARY

## MONTHLY RESULTS:

- Change in Net Assets is ($2.0) million, $3.1 million unfavorable to budget
- Operating deficit is $3.7 million, with a surplus in non-operating income of $1.7 million

### Change in Net Assets by Line of Business (LOB) ($ millions)

| MONTH-TO-DATE | | | |
|---|---|---|---|
| Actual | Budget | Variance | |
| (3.2) | 1.6 | (4.8) | Medi-Cal |
| (0.9) | (1.6) | 0.8 | OCC |
| 0.3 | (0.2) | 0.5 | OneCare |
| 0.0 | 0.1 | (0.1) | PACE |
| **(3.7)** | **(0.2)** | **(3.6)** | **Operating** |
| 1.7 | 1.3 | 0.5 | Inv./Rental Inc, MCO tax |
| **1.7** | **1.3** | **0.5** | **Non-Operating** |
| **(2.0)** | **1.1** | **(3.1)** | **TOTAL** |

# CalOptima
# Financial Dashboard
# For the One Month Ended July 31, 2019

## MONTH - TO - DATE

**Enrollment**

| | Actual | Budget | | Fav / (Unfav) | |
|---|---|---|---|---|---|
| Medi-Cal | 739,771 | 736,771 | ↑ | 3,000 | 0 4% |
| OneCare Connect | 14,257 | 14,216 | ↑ | 41 | 0 3% |
| OneCare | 1,530 | 1,494 | ↑ | 36 | 2 4% |
| PACE | 335 | 341 | ↓ | (6) | (1 8%) |
| Total | 755,893 | 752,822 | ↑ | 3,071 | 0 4% |

**Change in Net Assets (000)**

| | Actual | Budget | | Fav / (Unfav) | |
|---|---|---|---|---|---|
| Medi-Cal | $ (3,169) | $ 1,585 | ↓ | $ (4,754) | (299 9%) |
| OneCare Connect | (867) | (1,644) | ↑ | 777 | 47 3% |
| OneCare | 317 | (175) | ↑ | 492 | 281 5% |
| PACE | 1 | 66 | ↓ | (65) | (98 4%) |
| 505 Bldg | - | - | ↑ | - | 0 0% |
| Investment Income & Other | 1,748 | 1,250 | ↑ | 498 | 39 8% |
| Total | $ (1,970) | $ 1,082 | ↓ | $ (3,053) | (282 0%) |

**MLR**

| | Actual | Budget | | % Point Var |
|---|---|---|---|---|
| Medi-Cal | 97 6% | 95 3% | ↓ | (2 3) |
| OneCare Connect | 97 3% | 99 1% | ↑ | 1 8 |
| OneCare | 78 2% | 101 6% | ↑ | 23 3 |

**Administrative Cost (000)**

| | Actual | Budget | | Fav / (Unfav) | |
|---|---|---|---|---|---|
| Medi-Cal | $ 9,555 | $ 11,118 | ↑ | $ 1,563 | 14 1% |
| OneCare Connect | 1,537 | 1,857 | ↑ | 320 | 17 2% |
| OneCare | 79 | 150 | ↑ | 71 | 47 5% |
| PACE | 187 | 189 | ↑ | 2 | 1 3% |
| Total | $ 11,357 | $ 13,314 | ↑ | $ 1,956 | 14 7% |

**Total FTE s Month**

| | Actual | Budget | Fav / (Unfav) |
|---|---|---|---|
| Medi-Cal | 911 | 1,145 | 216 |
| OneCare Connect | 201 | 200 | (1) |
| OneCare | 3 | 9 | 24 |
| PACE | 69 | 91 | 21 |
| Total | 1,184 | 1,445 | 261 |

**MM per FTE**

| | Actual | Budget | Fav / (Unfav) |
|---|---|---|---|
| Medi-Cal | 812 | 643 | 168 |
| OneCare Connect | 71 | 71 | (0) |
| OneCare | 483 | 161 | 322 |
| PACE | 5 | 4 | 1 |
| Total | 1,371 | 879 | 492 |

## YEAR - TO - DATE

**Year To Date Enrollment**

| | Actual | Budget | | Fav / (Unfav) | |
|---|---|---|---|---|---|
| Medi-Cal | 739,771 | 736,771 | ↑ | 3,000 | 0 4% |
| OneCare Connect | 14,257 | 14,216 | ↑ | 41 | 0 3% |
| OneCare | 1,530 | 1,494 | ↑ | 36 | 2 4% |
| PACE | 335 | 341 | ↓ | (6) | (1 8%) |
| Total | 755,893 | 752,822 | ↑ | 3,071 | 0 4% |

**Change in Net Assets (000)**

| | Actual | Budget | | Fav / (Unfav) | |
|---|---|---|---|---|---|
| Medi-Cal | $ (3,169) | $ 1,585 | ↓ | $ (4,754) | (299 9%) |
| OneCare Connect | (867) | (1,644) | ↑ | 777 | 47 3% |
| OneCare | 317 | (175) | ↑ | 492 | 281 5% |
| PACE | 1 | 66 | ↓ | (65) | (98 4%) |
| 505 Bldg | - | - | ↑ | - | 0 0% |
| Investment Income & Other | 1,748 | 1,250 | ↑ | 498 | 39 8% |
| Total | $ (1,970) | $ 1,082 | ↓ | $ (3,053) | (282 0%) |

**MLR**

| | Actual | Budget | | % Point Var |
|---|---|---|---|---|
| Medi-Cal | 97 6% | 95 3% | ↓ | (2 3) |
| OneCare Connect | 97 3% | 99 1% | ↑ | 1 8 |
| OneCare | 78 2% | 101 6% | ↑ | 23 3 |

**Administrative Cost (000)**

| | Actual | Budget | | Fav / (Unfav) | |
|---|---|---|---|---|---|
| Medi-Cal | $ 9,555 | $ 11,118 | ↑ | $ 1,563 | 14 1% |
| OneCare Connect | 1,537 | 1,857 | ↑ | 320 | 17 2% |
| OneCare | 79 | 150 | ↑ | 71 | 47 5% |
| PACE | 187 | 189 | ↑ | 2 | 1 3% |
| Total | $ 11,357 | $ 13,314 | ↑ | $ 1,956 | 14 7% |

**Total FTE s YTD**

| | Actual | Budget | Fav / (Unfav) |
|---|---|---|---|
| Medi-Cal | 911 | 1,145 | 234 |
| OneCare Connect | 201 | 200 | (1) |
| OneCare | 3 | 9 | 6 |
| PACE | 69 | 91 | 21 |
| Total | 1,184 | 1,445 | 261 |

**MM per FTE**

| | Actual | Budget | Fav / (Unfav) |
|---|---|---|---|
| Medi-Cal | 812 | 643 | 168 |
| OneCare Connect | 71 | 71 | (0) |
| OneCare | 483 | 161 | 322 |
| PACE | 5 | 4 | 1 |
| Total | 1,371 | 879 | 492 |

## CalOptima - Consolidated
## Statement of Revenues and Expenses
## For the One Month Ended July 31, 2019

| | Actual | | Budget | | Variance | |
|---|---|---|---|---|---|---|
| | $ | PMPM | $ | PMPM | $ | PMPM |
| **MEMBER MONTHS** | 755,893 | | 752,822 | | 3,071 | |
| **REVENUE** | | | | | | |
| Medi-Cal | $ 270,359,229 | $ 365.46 | $ 269,641,291 | $ 365.98 | $ 717,938 | $ (0.52) |
| OneCare Connect | 24,752,077 | 1,736.14 | 23,658,718 | 1,664.23 | 1,093,359 | 71.91 |
| OneCare | 1,818,209 | 1,188.37 | 1,574,483 | 1,053.87 | 243,726 | 134.50 |
| PACE | 2,641,112 | 7,883.92 | 2,655,009 | 7,785.95 | (13,897) | 97.97 |
| Total Operating Revenue | 299,570,627 | 396.31 | 297,529,501 | 395.22 | 2,041,127 | 1.09 |
| **MEDICAL EXPENSES** | | | | | | |
| Medi-Cal | 263,973,294 | 356.83 | 256,938,333 | 348.74 | (7,034,961) | (8.09) |
| OneCare Connect | 24,082,014 | 1,689.14 | 23,445,434 | 1,649.23 | (636,580) | (39.91) |
| OneCare | 1,422,522 | 929.75 | 1,599,357 | 1,070.52 | 176,835 | 140.77 |
| PACE | 2,453,374 | 7,323.50 | 2,400,229 | 7,038.79 | (53,145) | (284.71) |
| Total Medical Expenses | 291,931,203 | 386.21 | 284,383,353 | 377.76 | (7,547,851) | (8.45) |
| **GROSS MARGIN** | 7,639,424 | 10.10 | 13,146,148 | 17.46 | (5,506,724) | (7.36) |
| **ADMINISTRATIVE EXPENSES** | | | | | | |
| Salaries and benefits | 7,885,217 | 10.43 | 8,483,577 | 11.27 | 598,360 | 0.84 |
| Professional fees | 91,097 | 0.12 | 462,135 | 0.61 | 371,038 | 0.49 |
| Purchased services | 1,029,209 | 1.36 | 1,233,276 | 1.64 | 204,067 | 0.28 |
| Printing & Postage | 359,067 | 0.48 | 565,630 | 0.75 | 206,563 | 0.27 |
| Depreciation & Amortization | 403,351 | 0.53 | 457,866 | 0.61 | 54,515 | 0.08 |
| Other expenses | 1,192,233 | 1.58 | 1,724,120 | 2.29 | 531,887 | 0.71 |
| Indirect cost allocation & Occupancy expense | 397,229 | 0.53 | 386,931 | 0.51 | (10,298) | (0.02) |
| Total Administrative Expenses | 11,357,403 | 15.03 | 13,313,535 | 17.68 | 1,956,132 | 2.65 |
| **INCOME (LOSS) FROM OPERATIONS** | (3,717,979) | (4.92) | (167,387) | (0.22) | (3,550,593) | (4.70) |
| **INVESTMENT INCOME** | | | | | | |
| Interest income | 3,003,627 | 3.97 | 1,250,000 | 1.66 | 1,753,627 | 2.31 |
| Realized gain/(loss) on investments | 276,337 | 0.37 | - | - | 276,337 | 0.37 |
| Unrealized gain/(loss) on investments | (1,532,166) | (2.03) | - | - | (1,532,166) | (2.03) |
| Total Investment Income | 1,747,798 | 2.31 | 1,250,000 | 1.66 | 497,798 | 0.65 |
| **CHANGE IN NET ASSETS** | **(1,970,181)** | **(2.61)** | **1,082,613** | **1.44** | **(3,052,794)** | **(4.05)** |
| **MEDICAL LOSS RATIO** | **97.4%** | | **95.6%** | | **(1.9%)** | |
| **ADMINISTRATIVE LOSS RATIO** | **3.8%** | | **4.5%** | | **0.7%** | |

## CalOptima - Consolidated - Month to Date
## Statement of Revenues and Expenses by LOB
## For the One Month Ended July 31, 2019

| | Medi-Cal Classic | Medi-Cal Expansion | Whole Child Model | Total Medi-Cal | OneCare Connect | OneCare | PACE | Consolidated |
|---|---|---|---|---|---|---|---|---|
| **MEMBER MONTHS** | 494,072 | 233,874 | 11,825 | 739,771 | 14,257 | 1,530 | 335 | 755,893 |
| **REVENUES** | | | | | | | | |
| Capitation Revenue | $ 143,553,009 | $ 103,663,269 | $ 23,142,951 | $ 270,359,229 | $ 24,752,077 | $ 1,818,209 | $ 2,641,112 | $ 299,570,627 |
| Other Income | - | - | | - | - | - | - | - |
| **Total Operating Revenue** | 143,553,009 | 103,663,269 | 23,142,951 | 270,359,229 | 24,752,077 | 1,818,209 | 2,641,112 | 299,570,627 |
| **MEDICAL EXPENSES** | | | | | | | | |
| Provider Capitation | 38,747,620 | 44,463,058 | 10,217,936 | 93,428,614 | 11,289,150 | 482,924 | | 105,200,688 |
| Facilities | 23,667,106 | 22,340,652 | 3,238,731 | 49,246,488 | 3,271,773 | 319,074 | 1,059,579 | 53,896,914 |
| Ancillary | - | - | | - | 727,111 | 71,901 | - | 799,012 |
| Professional Claims | 16,402,774 | 8,361,501 | 1,194,820 | 25,959,094 | - | - | 420,333 | 26,379,427 |
| Prescription Drugs | 29,047,231 | 22,320,842 | 566,219 | 51,934,292 | 5,716,226 | 494,170 | 214,473 | 58,359,160 |
| MLTSS | 26,905,350 | 2,791,074 | 7,658,945 | 37,355,369 | 1,503,480 | (2,476) | 25,654 | 38,882,027 |
| Medical Management | 2,027,447 | 1,014,719 | 391,185 | 3,433,351 | 1,150,294 | 56,929 | 649,949 | 5,290,522 |
| Quality Incentives | 918,519 | 472,735 | | 1,391,254 | 274,200 | | 4,549 | 1,670,003 |
| Reinsurance & Other | 667,267 | 548,593 | 8,973 | 1,224,832 | 149,781 | | 78,837 | 1,453,450 |
| **Total Medical Expenses** | 138,383,312 | 102,313,174 | 23,276,808 | 263,973,294 | 24,082,014 | 1,422,522 | 2,453,374 | 291,931,203 |
| **Medical Loss Ratio** | 97 0% | 98 7% | 100 6% | 97 6% | 97 3% | 78 2% | 92 9% | 97 4% |
| **GROSS MARGIN** | **5,169,697** | **1,350,096** | **(133,857)** | **6,385,935** | **670,063** | **395,688** | **187,738** | **7,639,424** |
| **ADMINISTRATIVE EXPENSES** | | | | | | | | |
| Salaries & Benefits | | | | 6,919,237 | 774,127 | 35,209 | 156,645 | 7,885,217 |
| Professional fees | | | | 91,947 | (850) | | | 91,097 |
| Purchased services | | | | 834,160 | 157,088 | 16,760 | 21,202 | 1,029,209 |
| Printing & Postage | | | | 317,141 | 50,085 | (8,879) | 719 | 359,067 |
| Depreciation & Amortization | | | | 401,259 | | | 2,092 | 403,351 |
| Other expenses | | | | 1,152,693 | 37,129 | | 2,412 | 1,192,233 |
| Indirect cost allocation & Occupancy | | | | (161,794) | 519,792 | 35,589 | 3,642 | 397,229 |
| **Total Administrative Expenses** | | | | 9,554,642 | 1,537,371 | 78,679 | 186,712 | 11,357,403 |
| **Admin Loss Ratio** | | | | 3 5% | 6 2% | 4 3% | 7 1% | 3 8% |
| **INCOME (LOSS) FROM OPERATIONS** | | | | (3,168,706) | (867,308) | 317,009 | 1,026 | (3,717,979) |
| **INVESTMENT INCOME** | | | | | | | | 1,747,798 |
| **CHANGE IN NET ASSETS** | | | | **$ (3,168,706)** | **$ (867,308)** | **$ 317,009** | **$ 1,026** | **$ (1,970,181)** |
| **BUDGETED CHANGE IN NET ASSETS** | | | | 1,585,417 | (1,643,841) | (174,627) | 65,664 | 1,082,613 |
| **VARIANCE TO BUDGET - FAV (UNFAV)** | | | | $ (4,754,124) | $ 776,533 | $ 491,636 | $ (64,638) | $ (3,052,794) |

**CalOptima - Consolidated**

**Enrollment Summary**

**For the One Month Ended July 31, 2019**

| Month-to-Date | | | | | Year-to-Date | | | |
|---|---|---|---|---|---|---|---|---|
| **Actual** | **Budget** | **Variance** | **%** | **Enrollment (By Aid Category)** | **Actual** | **Budget** | **Variance** | **%** |
| 65,252 | 65,188 | 64 | 0.1% | Aged | 65,252 | 65,188 | 64 | 0.1% |
| 566 | 615 | (49) | (8.0%) | BCCTP | 566 | 615 | (49) | (8.0%) |
| 44,910 | 43,866 | 1,044 | 2.4% | Disabled | 44,910 | 43,866 | 1,044 | 2.4% |
| 291,573 | 287,607 | 3,966 | 1.4% | TANF Child | 291,573 | 287,607 | 3,966 | 1.4% |
| 88,396 | 88,109 | 287 | 0.3% | TANF Adult | 88,396 | 88,109 | 287 | 0.3% |
| 3,375 | 3,404 | (29) | (0.9%) | LTC | 3,375 | 3,404 | (29) | (0.9%) |
| 233,874 | 235,042 | (1,168) | (0.5%) | MCE | 233,874 | 235,042 | (1,168) | (0.5%) |
| 11,825 | 12,940 | (1,115) | (8.6%) | WCM | 11,825 | 12,940 | (1,115) | (8.6%) |
| **739,771** | **736,771** | **3,000** | **0.4%** | **Medi-Cal** | **739,771** | **736,771** | **3,000** | **0.4%** |
| **14,257** | **14,216** | **41** | **0.3%** | **OneCare Connect** | **14,257** | **14,216** | **41** | **0.3%** |
| **1,530** | **1,494** | **36** | **2.4%** | **OneCare** | **1,530** | **1,494** | **36** | **2.4%** |
| **335** | **341** | **(6)** | **(1.8%)** | **PACE** | **335** | **341** | **(6)** | **(1.8%)** |
| **755,893** | **752,822** | **3,071** | **0.4%** | **CalOptima Total** | **755,893** | **752,822** | **3,071** | **0.4%** |

| Actual | Budget | Variance | % | **Enrollment (By Network)** | Actual | Budget | Variance | % |
|---|---|---|---|---|---|---|---|---|
| 163,254 | 163,394 | (140) | (0.1%) | HMO | 163,254 | 163,394 | (140) | (0.1%) |
| 211,497 | 211,592 | (95) | (0.0%) | PHC | 211,497 | 211,592 | (95) | (0.0%) |
| 189,144 | 188,911 | 233 | 0.1% | Shared Risk Group | 189,144 | 188,911 | 233 | 0.1% |
| 175,876 | 172,874 | 3,002 | 1.7% | Fee for Service | 175,876 | 172,874 | 3,002 | 1.7% |
| **739,771** | **736,771** | **3,000** | **0.4%** | **Medi-Cal** | **739,771** | **736,771** | **3,000** | **0.4%** |
| **14,257** | **14,216** | **41** | **0.3%** | **OneCare Connect** | **14,257** | **14,216** | **41** | **0.3%** |
| **1,530** | **1,494** | **36** | **2.4%** | **OneCare** | **1,530** | **1,494** | **36** | **2.4%** |
| **335** | **341** | **(6)** | **(1.8%)** | **PACE** | **335** | **341** | **(6)** | **(1.8%)** |
| **755,893** | **752,822** | **3,071** | **0.4%** | **CalOptima Total** | **755,893** | **752,822** | **3,071** | **0.4%** |

**CalOptima - Consolidated**
**Enrollment Trend by Network Type**
**Fiscal Year 2020**

| Network Type | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | MMs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **HMO** | | | | | | | | | | | | | |
| Aged | 3,723 | | | | | | | | | | | | 3,723 |
| BCCTP | 1 | | | | | | | | | | | | 1 |
| Disabled | 6,539 | | | | | | | | | | | | 6,539 |
| TANF Child | 54,046 | | | | | | | | | | | | 54,046 |
| TANF Adult | 27,944 | | | | | | | | | | | | 27,944 |
| LTC | 2 | | | | | | | | | | | | 2 |
| MCE | 68,973 | | | | | | | | | | | | 68,973 |
| WCM | 2,026 | | | | | | | | | | | | 2,026 |
| | **163,254** | | | | | | | | | | | | **163,254** |
| **PHC** | | | | | | | | | | | | | |
| Aged | 1,548 | | | | | | | | | | | | 1,548 |
| BCCTP | - | | | | | | | | | | | | - |
| Disabled | 5,416 | | | | | | | | | | | | 5,416 |
| TANF Child | 148,665 | | | | | | | | | | | | 148,665 |
| TANF Adult | 11,149 | | | | | | | | | | | | 11,149 |
| LTC | - | | | | | | | | | | | | - |
| MCE | 37,510 | | | | | | | | | | | | 37,510 |
| WCM | 7,209 | | | | | | | | | | | | |
| | **211,497** | | | | | | | | | | | | **211,497** |
| **Shared Risk Group** | | | | | | | | | | | | | |
| Aged | 3,569 | | | | | | | | | | | | 3,569 |
| BCCTP | - | | | | | | | | | | | | - |
| Disabled | 7,275 | | | | | | | | | | | | 7,275 |
| TANF Child | 63,291 | | | | | | | | | | | | 63,291 |
| TANF Adult | 28,681 | | | | | | | | | | | | 28,681 |
| LTC | 1 | | | | | | | | | | | | 1 |
| MCE | 84,595 | | | | | | | | | | | | 84,595 |
| WCM | 1,732 | | | | | | | | | | | | 1,732 |
| | **189,144** | | | | | | | | | | | | **189,144** |
| **Fee for Service (Dual)** | | | | | | | | | | | | | |
| Aged | 51,730 | | | | | | | | | | | | 51,730 |
| BCCTP | 15 | | | | | | | | | | | | 15 |
| Disabled | 20,752 | | | | | | | | | | | | 20,752 |
| TANF Child | - | | | | | | | | | | | | - |
| TANF Adult | 964 | | | | | | | | | | | | 964 |
| LTC | 3,044 | | | | | | | | | | | | 3,044 |
| MCE | 2,116 | | | | | | | | | | | | 2,116 |
| WCM | 15 | | | | | | | | | | | | 15 |
| | **78,636** | | | | | | | | | | | | **78,636** |
| **Fee for Service (Non-Dual)** | | | | | | | | | | | | | |
| Aged | 4,682 | | | | | | | | | | | | 4,682 |
| BCCTP | 550 | | | | | | | | | | | | 550 |
| Disabled | 4,928 | | | | | | | | | | | | 4,928 |
| TANF Child | 25,571 | | | | | | | | | | | | 25,571 |
| TANF Adult | 19,658 | | | | | | | | | | | | 19,658 |
| LTC | 328 | | | | | | | | | | | | 328 |
| MCE | 40,680 | | | | | | | | | | | | 40,680 |
| WCM | 843 | | | | | | | | | | | | 843 |
| | **97,240** | | | | | | | | | | | | **97,240** |
| **MEDI-CAL TOTAL** | | | | | | | | | | | | | |
| Aged | 65,252 | | | | | | | | | | | | 65,252 |
| BCCTP | 566 | | | | | | | | | | | | 566 |
| Disabled | 44,910 | | | | | | | | | | | | 44,910 |
| TANF Child | 291,573 | | | | | | | | | | | | 291,573 |
| TANF Adult | 88,396 | | | | | | | | | | | | 88,396 |
| LTC | 3,375 | | | | | | | | | | | | 3,375 |
| MCE | 233,874 | | | | | | | | | | | | 233,874 |
| WCM | 11,825 | | | | | | | | | | | | 11,825 |
| | **739,771** | | | | | | | | | | | | **739,771** |
| **OneCare Connect** | 14,257 | | | | | | | | | | | | 14,257 |
| **OneCare** | 1,530 | | | | | | | | | | | | 1,530 |
| **PACE** | 335 | | | | | | | | | | | | 335 |
| **TOTAL** | **755,893** | | | | | | | | | | | | **755,893** |

**ENROLLMENT:**

**Overall** July enrollment was 755,893

- Favorable to budget 3,071 or 0.4%
- Decreased 4,030 or 0.5% from prior month (June 2019)
- Decreased 22,641 or 2.9% from prior year (July 2018)

**Medi-Cal** enrollment was 739,771

- Favorable to budget 3,000 or 0.4%
  - ➢ Temporary Assistance for Needy Families (TANF) favorable 4,253
  - ➢ Seniors and Persons with Disabilities (SPD) favorable 1,059
  - ➢ Medi-Cal Expansion (MCE) unfavorable 1,168
  - ➢ Whole Child Model (WCM) unfavorable 1,115
  - ➢ Long-Term Care (LTC) unfavorable 29
- Decreased 4,165 from prior month

**OneCare Connect** enrollment was 14,257

- Favorable to budget 41 or 0.3%
- Increased 134 from prior month

**OneCare** enrollment was 1,530

- Favorable to budget 36 or 2.4%
- Decreased 7 from prior month

**PACE** enrollment was 335

- Unfavorable to budget 6 or 1.8%
- Increased 8 from prior month

# CalOptima
## Medi-Cal Total
## Statement of Revenues and Expenses
## For the One Month Ending July 31, 2019

| Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Variance | % Variance | | Actual | Budget | $ Variance | % Variance |
| **739,771** | **736,771** | **3,000** | **0.4%** | **Member Months** | **739,771** | **736,771** | **3,000** | **0.4%** |
| | | | | **Revenues** | | | | |
| 270,359,229 | 269,641,291 | 717,938 | 0 3% | Capitation revenue | 270,359,229 | 269,641,291 | 717,938 | 0 3% |
| - | - | - | 0 0% | Other income | - | - | - | 0 0% |
| **270,359,229** | **269,641,291** | **717,938** | **0.3%** | **Total Operating Revenue** | **270,359,229** | **269,641,291** | **717,938** | **0.3%** |
| | | | | **Medical Expenses** | | | | |
| 94,819,868 | 95,550,257 | 730,389 | 0 8% | Provider capitation | 94,819,868 | 95,550,257 | 730,389 | 0 8% |
| 49,246,488 | 48,541,875 | (704,614) | (1 5%) | Facilities | 49,246,488 | 48,541,875 | (704,614) | (1 5%) |
| 25,959,094 | 23,225,102 | (2,733,992) | (11 8%) | Professional Claims | 25,959,094 | 23,225,102 | (2,733,992) | (11 8%) |
| 51,934,292 | 44,399,007 | (7,535,285) | (17 0%) | Prescription drugs | 51,934,292 | 44,399,007 | (7,535,285) | (17 0%) |
| 37,355,369 | 37,412,016 | 56,647 | 0 2% | MLTSS | 37,355,369 | 37,412,016 | 56,647 | 0 2% |
| 3,433,351 | 4,608,043 | 1,174,692 | 25 5% | Medical management | 3,433,351 | 4,608,043 | 1,174,692 | 25 5% |
| 1,224,832 | 3,202,034 | 1,977,202 | 61 7% | Reinsurance & other | 1,224,832 | 3,202,034 | 1,977,202 | 61 7% |
| **263,973,294** | **256,938,333** | **(7,034,961)** | **(2.7%)** | **Total Medical Expenses** | **263,973,294** | **256,938,333** | **(7,034,961)** | **(2.7%)** |
| **6,385,935** | **12,702,958** | **(6,317,023)** | **(49.7%)** | **Gross Margin** | **6,385,935** | **12,702,958** | **(6,317,023)** | **(49.7%)** |
| | | | | **Administrative Expenses** | | | | |
| 6,919,237 | 7,431,227 | 511,990 | 6 9% | Salaries, wages & employee benefits | 6,919,237 | 7,431,227 | 511,990 | 6 9% |
| 91,947 | 362,706 | 270,759 | 74 6% | Professional fees | 91,947 | 362,706 | 270,759 | 74 6% |
| 834,160 | 954,253 | 120,093 | 12 6% | Purchased services | 834,160 | 954,253 | 120,093 | 12 6% |
| 317,141 | 442,570 | 125,429 | 28 3% | Printing and postage | 317,141 | 442,570 | 125,429 | 28 3% |
| 401,259 | 455,750 | 54,491 | 12 0% | Depreciation and amortization | 401,259 | 455,750 | 54,491 | 12 0% |
| 1,152,693 | 1,643,358 | 490,665 | 29 9% | Other operating expenses | 1,152,693 | 1,643,358 | 490,665 | 29 9% |
| (161,794) | (172,323) | (10,529) | (6 1%) | Indirect cost allocation, Occupancy Expense | (161,794) | (172,323) | (10,529) | (6 1%) |
| **9,554,642** | **11,117,541** | **1,562,899** | **14.1%** | **Total Administrative Expenses** | **9,554,642** | **11,117,541** | **1,562,899** | **14.1%** |
| | | | | **Operating Tax** | | | | |
| - | 11,358,122 | (11,358,122) | (100 0%) | Tax Revenue | - | 11,358,122 | (11,358,122) | (100 0%) |
| - | - | - | 0 0% | Premium tax expense | - | - | - | 0 0% |
| - | 11,358,122 | 11,358,122 | 100 0% | Sales tax expense | - | 11,358,122 | 11,358,122 | 100 0% |
| - | - | - | **0.0%** | **Total Net Operating Tax** | - | - | - | **0.0%** |
| | | | | **Grant Income** | | | | |
| 8,909 | - | 8,909 | 0 0% | Grant Revenue | 8,909 | - | 8,909 | 0 0% |
| - | - | - | 0 0% | Grant expense - Service Partner | - | - | - | 0 0% |
| 8,909 | - | (8,909) | 0 0% | Grant expense - Administrative | 8,909 | - | (8,909) | 0 0% |
| - | - | - | **0.0%** | **Total Grant Income** | - | - | - | **0.0%** |
| **(3,168,706)** | **1,585,417** | **(4,754,124)** | **(299.9%)** | **Change in Net Assets** | **(3,168,706)** | **1,585,417** | **(4,754,124)** | **(299.9%)** |
| ***97.6%*** | ***95.3%*** | ***(2.3%)*** | ***(2.5%)*** | ***Medical Loss Ratio*** | ***97.6%*** | ***95.3%*** | ***(2.3%)*** | ***(2.5%)*** |
| ***3.5%*** | ***4.1%*** | ***0.6%*** | ***14.3%*** | ***Admin Loss Ratio*** | ***3.5%*** | ***4.1%*** | ***0.6%*** | ***14.3%*** |

## MEDI-CAL INCOME STATEMENT - JULY MONTH:

**REVENUES** of $270.4 million are favorable to budget $0.7 million driven by:

- Favorable volume related variance of $1.1 million
- Unfavorable price related variance of $0.4 million due to:
  - $.5 million of Hepatitis C revenue

**MEDICAL EXPENSES** of $264.0 million are unfavorable to budget $7.0 million driven by:

- ❖ Due to claim lag and limited information available, most of WCM medical expenses were estimated based on budget assumptions in July 2019

- **Prescription Drug** expense is unfavorable to budget $7.5 million due to high utilization during the month
- **Professional Claims** expense is unfavorable to budget $2.7 million due Proposition 56 and Incurred But Not Reported (IBNR) claims
- **Reinsurance & Other** expense is favorable to budget $2.0 million due to budgeting of homeless health initiatives
- **Medical Management** expense is favorable to budget $1.2 million

**ADMINISTRATIVE EXPENSES** of $9.6 million are favorable to budget $1.6 million driven by:

- Salaries & Benefit expenses are favorable to budget $0.5 million due to open positions
- Other Non-Salary expenses are favorable to budget $1.1 million

**CHANGE IN NET ASSETS is** ($3.2) million for the month, unfavorable to budget $4.8 million

# CalOptima
## OneCare Connect Total
## Statement of Revenue and Expenses
## For the One Month Ending July 31, 2019

| Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Variance | % Variance | | Actual | Budget | $ Variance | % Variance |
| **14,257** | **14,216** | **41** | **0.3%** | **Member Months** | **14,257** | **14,216** | **41** | **0.3%** |
| | | | | Revenues | | | | |
| 2,288,521 | 2,816,576 | (528,055) | (18.7%) | Medi-Cal Capitation revenue | 2,288,521 | 2,816,576 | (528,055) | (18.7%) |
| 16,812,863 | 16,064,864 | 747,999 | 4.7% | Medicare Capitation revenue part C | 16,812,863 | 16,064,864 | 747,999 | 4.7% |
| 5,650,693 | 4,777,278 | 873,415 | 18.3% | Medicare Capitation revenue part D | 5,650,693 | 4,777,278 | 873,415 | 18.3% |
| - | - | - | 0.0% | Other Income | - | - | - | 0.0% |
| **24,752,077** | **23,658,718** | **1,093,359** | **4.6%** | **Total Operating Revenue** | **24,752,077** | **23,658,718** | **1,093,359** | **4.6%** |
| | | | | **Medical Expenses** | | | | |
| 11,563,350 | 10,860,214 | (703,136) | (6.5%) | Provider capitation | 11,563,350 | 10,860,214 | (703,136) | (6.5%) |
| 3,271,773 | 3,486,647 | 214,874 | 6.2% | Facilities | 3,271,773 | 3,486,647 | 214,874 | 6.2% |
| 727,111 | 684,119 | (42,992) | (6.3%) | Ancillary | 727,111 | 684,119 | (42,992) | (6.3%) |
| 1,503,480 | 1,587,395 | 83,915 | 5.3% | Long Term Care | 1,503,480 | 1,587,395 | 83,915 | 5.3% |
| 5,716,226 | 5,473,352 | (242,874) | (4.4%) | Prescription drugs | 5,716,226 | 5,473,352 | (242,874) | (4.4%) |
| 1,150,294 | 1,138,265 | (12,029) | (1.1%) | Medical management | 1,150,294 | 1,138,265 | (12,029) | (1.1%) |
| 149,781 | 215,442 | 65,661 | 30.5% | Other medical expenses | 149,781 | 215,442 | 65,661 | 30.5% |
| **24,082,014** | **23,445,434** | **(636,580)** | **(2.7%)** | **Total Medical Expenses** | **24,082,014** | **23,445,434** | **(636,580)** | **(2.7%)** |
| **670,063** | **213,284** | **456,779** | **214.2%** | **Gross Margin** | **670,063** | **213,284** | **456,779** | **214.2%** |
| | | | | **Administrative Expenses** | | | | |
| 774,127 | 848,800 | 74,673 | 8.8% | Salaries, wages & employee benefits | 774,127 | 848,800 | 74,673 | 8.8% |
| (850) | 77,796 | 78,646 | 101.1% | Professional fees | (850) | 77,796 | 78,646 | 101.1% |
| 157,088 | 242,989 | 85,901 | 35.4% | Purchased services | 157,088 | 242,989 | 85,901 | 35.4% |
| 50,085 | 95,860 | 45,775 | 47.8% | Printing and postage | 50,085 | 95,860 | 45,775 | 47.8% |
| - | - | - | 0.0% | Depreciation & amortization | - | - | - | 0.0% |
| 37,129 | 71,888 | 34,759 | 48.4% | Other operating expenses | 37,129 | 71,888 | 34,759 | 48.4% |
| 519,792 | 519,792 | - | 0.0% | Indirect cost allocation | 519,792 | 519,792 | - | 0.0% |
| **1,537,371** | **1,857,125** | **319,754** | **17.2%** | **Total Administrative Expenses** | **1,537,371** | **1,857,125** | **319,754** | **17.2%** |
| **(867,308)** | **(1,643,841)** | **776,533** | **47.2%** | **Change in Net Assets** | **(867,308)** | **(1,643,841)** | **776,533** | **47.2%** |
| ***97.3%*** | ***99.1%*** | ***1.8%*** | ***1.8%*** | ***Medical Loss Ratio*** | ***97.3%*** | ***99.1%*** | ***1.8%*** | ***1.8%*** |
| ***6.2%*** | ***7.8%*** | ***1.6%*** | ***20.9%*** | ***Admin Loss Ratio*** | ***6.2%*** | ***7.8%*** | ***1.6%*** | ***20.9%*** |

## ONECARE CONNECT INCOME STATEMENT - JULY MONTH:

**REVENUES** of $24.8 million are favorable to budget $1.1 million driven by:

- Favorable volume related variance of $0.1 million
- Favorable price related variance of $1.0 million due to favorable rates

**MEDICAL EXPENSES** of $24.1 million are unfavorable to budget $0.6 million driven by:

- Unfavorable volume related variance of $0.1 million
- Unfavorable price related variance of $0.6 million

**ADMINISTRATIVE EXPENSES** of $1.5 million are favorable to budget $0.3 million

**CHANGE IN NET ASSETS** is ($0.9) million, favorable to budget $0.8 million

# CalOptima
## OneCare
## Statement of Revenues and Expenses
## For the One Month Ending July 31, 2019

| Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Variance | % Variance | | Actual | Budget | $ Variance | % Variance |
| **1,530** | **1,494** | **36** | **2.4%** | **Member Months** | **1,530** | **1,494** | **36** | **2.4%** |
| | | | | **Revenues** | | | | |
| 1,240,407 | 1,065,775 | 174,632 | 16 4% | Medicare Part C revenue | 1,240,407 | 1,065,775 | 174,632 | 16 4% |
| 577,802 | 508,708 | 69,094 | 13 6% | Medicare Part D revenue | 577,802 | 508,708 | 69,094 | 13 6% |
| **1,818,209** | **1,574,483** | **243,726** | **15.5%** | **Total Operating Revenue** | **1,818,209** | **1,574,483** | **243,726** | **15.5%** |
| | | | | **Medical Expenses** | | | | |
| 482,924 | 422,758 | (60,166) | (14 2%) | Provider capitation | 482,924 | 422,758 | (60,166) | (14 2%) |
| 319,074 | 509,111 | 190,037 | 37 3% | Inpatient | 319,074 | 509,111 | 190,037 | 37 3% |
| 71,901 | 55,586 | (16,315) | (29 4%) | Ancillary | 71,901 | 55,586 | (16,315) | (29 4%) |
| (2,476) | 45,673 | 48,149 | 105 4% | Skilled nursing facilities | (2,476) | 45,673 | 48,149 | 105 4% |
| 494,170 | 505,905 | 11,735 | 2 3% | Prescription drugs | 494,170 | 505,905 | 11,735 | 2 3% |
| 56,929 | 49,541 | (7,388) | (14 9%) | Medical management | 56,929 | 49,541 | (7,388) | (14 9%) |
| - | 10,783 | 10,783 | 100 0% | Other medical expenses | - | 10,783 | 10,783 | 100 0% |
| **1,422,522** | **1,599,357** | **176,835** | **11.1%** | **Total Medical Expenses** | **1,422,522** | **1,599,357** | **176,835** | **11.1%** |
| **395,688** | **(24,874)** | **420,562** | **1690.8%** | **Gross Margin** | **395,688** | **(24,874)** | **420,562** | **1690.8%** |
| | | | | **Administrative Expenses** | | | | |
| 35,209 | 54,216 | 19,007 | 35 1% | Salaries, wages & employee benefits | 35,209 | 54,216 | 19,007 | 35 1% |
| - | 21,480 | 21,480 | 100 0% | Professional fees | - | 21,480 | 21,480 | 100 0% |
| 16,760 | 17,063 | 303 | 1 8% | Purchased services | 16,760 | 17,063 | 303 | 1 8% |
| (8,879) | 16,667 | 25,546 | 153 3% | Printing and postage | (8,879) | 16,667 | 25,546 | 153 3% |
| - | 4,738 | 4,738 | 100 0% | Other operating expenses | - | 4,738 | 4,738 | 100 0% |
| 35,589 | 35,589 | - | 0 0% | Indirect cost allocation, occupancy expense | 35,589 | 35,589 | - | 0 0% |
| **78,679** | **149,753** | **71,074** | **47.5%** | **Total Administrative Expenses** | **78,679** | **149,753** | **71,074** | **47.5%** |
| **317,009** | **(174,627)** | **491,636** | **281.5%** | **Change in Net Assets** | **317,009** | **(174,627)** | **491,636** | **281.5%** |
| ***78.2%*** | ***101.6%*** | ***23.3%*** | ***23.0%*** | ***Medical Loss Ratio*** | ***78.2%*** | ***101.6%*** | ***23.3%*** | ***23.0%*** |
| ***4.3%*** | ***9.5%*** | ***5.2%*** | ***54.5%*** | ***Admin Loss Ratio*** | ***4.3%*** | ***9.5%*** | ***5.2%*** | ***54.5%*** |

# CalOptima
# PACE
## Statement of Revenues and Expenses
## For the One Month Ending July 31, 2019

| Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Variance | % Variance | | Actual | Budget | $ Variance | % Variance |
| **335** | **341** | **(6)** | **(1.8%)** | **Member Months** | **335** | **341** | **(6)** | **-1.8%** |
| | | | | **Revenues** | | | | |
| 2,069,312 | 2,050,358 | 18,954 | 0 9% | Medi-Cal capitation revenue | 2,069,312 | 2,050,358 | 18,954 | 0 9% |
| 458,891 | 478,895 | (20,004) | (4 2%) | Medicare Part C revenue | 458,891 | 478,895 | (20,004) | (4 2%) |
| 112,909 | 125,756 | (12,847) | (10 2%) | Medicare Part D revenue | 112,909 | 125,756 | (12,847) | (10 2%) |
| **2,641,112** | **2,655,009** | **(13,897)** | **(0.5%)** | **Total Operating Revenue** | **2,641,112** | **2,655,009** | **(13,897)** | **(0.5%)** |
| | | | | **Medical Expenses** | | | | |
| 649,949 | 893,166 | 243,217 | 27 2% | Medical Management | 649,949 | 893,166 | 243,217 | 27 2% |
| 1,059,579 | 502,991 | (556,588) | (110 7%) | Claims payments to hospitals | 1,059,579 | 502,991 | (556,588) | (110 7%) |
| 420,333 | 552,727 | 132,394 | 24 0% | Professional claims | 420,333 | 552,727 | 132,394 | 24 0% |
| 78,837 | 215,784 | 136,947 | 63 5% | Patient transportation | 78,837 | 215,784 | 136,947 | 63 5% |
| 214,473 | 209,777 | (4,696) | (2 2%) | Prescription drugs | 214,473 | 209,777 | (4,696) | (2 2%) |
| 25,654 | 19,117 | (6,537) | (34 2%) | MLTSS | 25,654 | 19,117 | (6,537) | (34 2%) |
| 4,549 | 6,667 | 2,118 | 31 8% | Other Expenses | 4,549 | 6,667 | 2,118 | 31 8% |
| **2,453,374** | **2,400,229** | **(53,145)** | **(2.2%)** | **Total Medical Expenses** | **2,453,374** | **2,400,229** | **(53,145)** | **(2.2%)** |
| **187,738** | **254,780** | **(67,042)** | **-26.3%** | **Gross Margin** | **187,738** | **254,780** | **(67,042)** | **-26.3%** |
| | | | | **Administrative Expenses** | | | | |
| 156,645 | 149,334 | (7,311) | (4 9%) | Salaries, wages & employee benefits | 156,645 | 149,334 | (7,311) | (4 9%) |
| - | 153 | 153 | 100 0% | Professional fees | - | 153 | 153 | 100 0% |
| 21,202 | 18,971 | (2,231) | (11 8%) | Purchased services | 21,202 | 18,971 | (2,231) | (11 8%) |
| 719 | 10,533 | 9,814 | 93 2% | Printing and postage | 719 | 10,533 | 9,814 | 93 2% |
| 2,092 | 2,116 | 24 | 1 1% | Depreciation & amortization | 2,092 | 2,116 | 24 | 1 1% |
| 2,412 | 4,136 | 1,724 | 41 7% | Other operating expenses | 2,412 | 4,136 | 1,724 | 41 7% |
| 3,642 | 3,873 | 231 | 6 0% | Indirect cost allocation, Occupancy Expense | 3,642 | 3,873 | 231 | 6 0% |
| **186,712** | **189,116** | **2,404** | **1.3%** | **Total Administrative Expenses** | **186,712** | **189,116** | **2,404** | **1.3%** |
| **1,026** | **65,664** | **(64,638)** | **(98.4%)** | **Change in Net Assets** | **1,026** | **65,664** | **(64,638)** | **(98.4%)** |
| ***92.9%*** | ***90.4%*** | ***(2.5%)*** | ***(2.8%)*** | ***Medical Loss Ratio*** | ***92.9%*** | ***90.4%*** | ***(2.5%)*** | ***(2.8%)*** |
| ***7.1%*** | ***7.1%*** | ***0.1%*** | ***0.8%*** | ***Admin Loss Ratio*** | ***7.1%*** | ***7.1%*** | ***0.1%*** | ***0.8%*** |

# CalOptima
## Building 505 - City Parkway
## Statement of Revenues and Expenses
## For the One Month Ending July 31, 2019

| Month Actual | Month Budget | Month $ Variance | Month % Variance | | YTD Actual | YTD Budget | YTD $ Variance | YTD % Variance |
|---|---|---|---|---|---|---|---|---|
| | | | | **Revenues** | | | | |
| - | - | - | 0.0% | Rental Income | - | - | - | 0.0% |
| **-** | **-** | **-** | **0.0%** | **Total Operating Revenue** | **-** | **-** | **-** | **0.0%** |
| | | | | **Administrative Expenses** | | | | |
| 42,333 | 23,101 | (19,232) | (83.3%) | Purchase services | 42,333 | 23,101 | (19,232) | (83.3%) |
| 164,494 | 174,725 | 10,231 | 5.9% | Depreciation & amortization | 164,494 | 174,725 | 10,231 | 5.9% |
| 17,476 | 15,866 | (1,610) | (10.2%) | Insurance expense | 17,476 | 15,866 | (1,610) | (10.2%) |
| 96,155 | 140,162 | 44,007 | 31.4% | Repair and maintenance | 96,155 | 140,162 | 44,007 | 31.4% |
| 69,524 | 46,432 | (23,092) | (49.7%) | Other Operating Expense | 69,524 | 46,432 | (23,092) | (49.7%) |
| (389,983) | (400,286) | (10,303) | (2.6%) | Indirect allocation, Occupancy | (389,983) | (400,286) | (10,303) | (2.6%) |
| **(0)** | **-** | **0** | **0.0%** | **Total Administrative Expenses** | **(0)** | **-** | **0** | **0.0%** |
| **0** | **-** | **0** | **0.0%** | **Change in Net Assets** | **0** | **-** | **0** | **0.0%** |

## OTHER INCOME STATEMENTS - JULY MONTH:

## ONECARE INCOME STATEMENT

**CHANGE IN NET ASSETS** is $317.0 thousand, $491.6 thousand favorable to budget

## PACE INCOME STATEMENT

**CHANGE IN NET ASSETS** is $1.0 thousand, $64.6 thousand unfavorable to budget

# CalOptima
# Balance Sheet
# July 31, 2019

**ASSETS**

| | |
|---|---:|
| Current Assets | |
| Operating Cash | $294,005,950 |
| Investments | 589,942,289 |
| Capitation receivable | 299,059,139 |
| Receivables - Other | 36,234,453 |
| Prepaid expenses | 6,875,890 |
| **Total Current Assets** | **1,226,117,721** |
| Capital Assets | |
| Furniture & Equipment | 37,086,365 |
| Building/Leasehold Improvements | 7,090,283 |
| 505 City Parkway West | 50,464,989 |
| | 94,641,636 |
| Less: accumulated depreciation | (47,103,553) |
| Capital assets, net | 47,538,083 |
| Other Assets | |
| Restricted Deposit & Other | 300,000 |
| Homeless Health Reserve | 60,000,000 |
| Board-designated assets: | |
| Cash and Cash Equivalents | 13,335,635 |
| Long-term Investments | 546,836,157 |
| Total Board-designated Assets | 560,171,792 |
| **Total Other Assets** | 620,471,792 |
| **TOTAL ASSETS** | **1,894,127,596** |
| Deferred Outflows | |
| Pension Contributions | 1,242,962 |
| Difference in Experience | 3,419,328 |
| Excess Earning | - |
| Changes in Assumptions | 6,428,159 |
| **TOTAL ASSETS & DEFERRED OUTFLOWS** | **1,905,218,045** |

**LIABILITIES & NET POSITION**

| | |
|---|---:|
| Current Liabilities | |
| Accounts Payable | $8,195,445 |
| Medical Claims liability | 728,775,781 |
| Accrued Payroll Liabilities | 12,720,471 |
| Deferred Revenue | 39,917,963 |
| Deferred Lease Obligations | 38,153 |
| Capitation and Withholds | 126,031,885 |
| **Total Current Liabilities** | **915,679,698** |
| Other (than pensions) post employment benefits liability | 24,825,940 |
| Net Pension Liabilities | 23,732,883 |
| Bldg 505 Development Rights | - |
| **TOTAL LIABILITIES** | **964,238,521** |
| Deferred Inflows | |
| Change in Assumptions | 7,250,505 |
| Excess Earnings | 156,330 |
| Net Position | |
| TNE | 94,829,046 |
| Funds in Excess of TNE | 838,743,643 |
| **TOTAL NET POSITION** | 933,572,689 |
| **TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION** | **1,905,218,045** |

**CalOptima**
**Board Designated Reserve and TNE Analysis**
**as of July 31, 2019**

| Type | Reserve Name | Market Value | Benchmark | | Variance | |
|---|---|---|---|---|---|---|
| | | | Low | High | Mkt - Low | Mkt - High |
| | Tier 1 - Payden & Rygel | 153,459,393 | | | | |
| | Tier 1 - Logan Circle | 152,583,250 | | | | |
| | Tier 1 - Wells Capital | 152,692,768 | | | | |
| Board-designated Reserve | | | | | | |
| | | 458,735,412 | 304,878,980 | 476,182,420 | 153,856,432 | (17,447,008) |
| TNE Requirement | Tier 2 - Logan Circle | 101,436,380 | 94,829,046 | 94,829,046 | 6,607,334 | 6,607,334 |
| | **Consolidated:** | **560,171,792** | **399,708,026** | **571,011,466** | **160,463,766** | **(10,839,674)** |
| | *Current reserve level* | *1.96* | *1.40* | *2.00* | | |

**CalOptima**
**Statement of Cash Flows**
**as of July 31, 2019**

| | **Month Ended** | **Year-To-Date** |
|---|---|---|
| CASH FLOWS FROM OPERATING ACTIVITIES: | | |
| Change in net assets | (1,970,181) | (1,970,181) |
| Adjustments to reconcile change in net assets | | |
| to net cash provided by operating activities | | |
| Depreciation and amortization | 567,845 | 567,845 |
| Changes in assets and liabilities: | | |
| Prepaid expenses and other | (1,088,149) | (1,088,149) |
| Catastrophic reserves | | |
| Capitation receivable | 16,648,176 | 16,648,176 |
| Medical claims liability | (23,535,170) | (23,535,170) |
| Deferred revenue | (11,116,801) | (11,116,801) |
| Payable to providers | 17,128,744 | 17,128,744 |
| Accounts payable | (32,758,283) | (32,758,283) |
| Other accrued liabilities | 245,401 | 245,401 |
| Net cash provided by/(used in) operating activities | (35,878,418) | (35,878,418) |
| 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 | (16,235,993) | (16,235,993) |
| Change in Property and Equipment | (1,481,039) | (1,481,039) |
| Change in Board designated reserves | (26,384) | (26,384) |
| Change in Homeless Health reserve | - | - |
| Net cash provided by/(used in) investing activities | (17,743,416) | (17,743,416) |
| NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS | (53,621,834) | (53,621,834) |
| CASH AND CASH EQUIVALENTS, beginning of period | 347,627,784 | 347,627,784 |
| **CASH AND CASH EQUIVALENTS, end of period** | **294,005,950** | **294,005,950** |

## BALANCE SHEET - JULY MONTH:

**ASSETS** of $1.9 billion decreased $52.0 million from June or 2.7%

- **Operating Cash** decreased $53.6 million primarily due to the quarterly premium tax payment of $34.2 million and the timing of cash flow needs
- **Investments** increased $16.2 million due to cash based on the timing of cash flow needs
- **Receivables – Other** decreased $12.7 million due to timing of Department of Health Care Services (DHCS) tax payments

**LIABILITIES** of $964.2 million decreased $50.0 million from June or 4.9%

- **Accounts Payable** decreased $34.5 million due to the timing of the quarterly Managed Care Organization (MCO) tax payment
- **Medical Claims Liability** decreased $23.5 million due to decrease in liability accruals
- **Deferred Revenue** decreased $11.1 million due to cash transfer for Be Well OC
- **Capitation and Withholds** increased $17.1 million due to increase in estimated payable for Proposition 56

**NET ASSETS** total $933.6 million

**Homeless Health Initiatives and Allocated Funds**
**Reporting for July 31, 2019**

| | | Amount |
|---|---|---|
| **Program Commitment** | | **$ 100,000,000** |
| **Funds Allocated** | | |
| Be Well OC | $ 11,400,000 | |
| Recuperative Care | 11,000,000 | |
| Clinical Field Team Start-up & FQHC's | 1,600,000 | |
| Homeless Response Team (CalOptima) | 6,000,000 | |
| Homeless Coordination at Hospitals | 10,000,000 | |
| Remaining Pledge for new initiatives | | 40,000,000 |
| **Program Commitment Balance, available for new initiatives** | | **$ 60,000,000** |

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 July 2019**

| 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 (Huma 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 |

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000. \
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

**Board of Directors' Meeting**
**September 5, 2019**

# Monthly Compliance Report

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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

- CY 2014 Part C Contract-Level Risk Adjustment Data Validation (RADV) Audit:

  On February 26, 2019, the Centers for Medicare & Medicaid Services (CMS) notified CalOptima that its OneCare program has been selected to participate in the CY 2014 Contract-Level Risk Adjustment Data Validation (RADV) audit. CMS will be conducting a medical records review to validate the accuracy of the CY 2014 Medicare Part C risk adjustment data and payments. The collection of medical records and medical director/review approval began in April and will continue through August 9, 2019. The deadline for submission of medical records for the selected enrollees is August 20, 2019.

- Compliance Program Effectiveness (CPE) Audit (OneCare and OneCare Connect):

  CalOptima is required to conduct an independent audit on the effectiveness of its compliance program on an annual basis, and to share the results with its governing body. As such, CalOptima has engaged an independent consultant to conduct the audit to ensure that its compliance program is administering the elements of an effective compliance program as outlined in the CMS Medicare Parts C and D Program Audit Protocols. The audit is scheduled to take place from August through October 2019. CalOptima is currently preparing documents and universes in preparation for the onsite audit scheduled for the week of September 23, 2019.

2. OneCare Connect

- CY 2018 Performance Measure Validation (PMV):

  On May 21, 2019, CMS provided Medicare-Medicaid Plans (MMPs) with an initial notification of upcoming PMV efforts for the following 2018 measurement year elements:

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- MMP Core 2.1: Members with an assessment completed within 90 days of enrollment
- MMP Core 3.2: Members with a care plan completed within 90 days of enrollment

MMPs are required to report various monitoring and performance measures, as outlined in the MMP core and state-specific reporting requirements. In order to ensure MMPs' reported data are reliable, valid, complete, and comparable, CMS conducts ongoing PMV of select core and state-specific measures. On June 25, 2019, CMS held a kick-off call to provide an overview of the upcoming webinar review scheduled for September 18, 2019.

3. Medi-Cal

- 2019 Medi-Cal Audit:

  The Department of Health Care Services (DHCS) conducted its annual audit of CalOptima's Medi-Cal program from February 4 - 15, 2019. The audit covered the review period of February 1, 2018 through January 31, 2019, and consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity. On June 25, 2019, the DHCS issued its final audit report to CalOptima, which outlined three (3) findings in the areas of case management and coordination of care, access and availability of care, and quality management. CalOptima submitted a timely Corrective Action Plan (CAP) to DHCS, and it is currently under review.

- Rate Development Template (RDT) Audit:

  On May 30, 2019, Mercer and the DHCS engaged CalOptima for the RDT audit, which will focus on the accuracy and completeness of calendar year 2017 Medi-Cal RDT encounter and financial data submitted to the DHCS as part of the rate development process for 2019-2020.

  On August 7, 2019, Mercer auditors came onsite to review CalOptima's claims systems as well as conduct staff interviews. CalOptima anticipates a final draft report from Mercer in the coming weeks. CalOptima will have one (1) week to provide any feedback before Mercer communicates the report to the DHCS for final review and approval.

- Department of Managed Health Care (DMHC) Routine Examination:

  On August 8, 2019, the DMHC engaged CalOptima for the tri-annual routine examination. This examination will review CalOptima's fiscal and administrative affairs and will include an examination of CalOptima's financial reports. CalOptima's last routine examination was conducted in 2016 and identified one (1) deficiency.

 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. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

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- CMS Medicaid Expansion Medical Loss Ratio (MLR) Examination:

  On April 1, 2019, CMS informed CalOptima that it will perform a comprehensive examination and validation of California Medicaid managed care plans' MLR reporting for the reporting periods January 1, 2014 to June 30, 2015 and July 1, 2015 to June 30, 2016. The overall purpose of the examination is to ensure that the financial information submitted by the Medicaid managed care plans and used by the DHCS to perform the MLR calculations is consistent with contractual obligations and matches each Medicaid managed care plan's internal data and accounting systems. CMS expects that the review will be completed within six (6) months after all the data have been received by the reviewing contractor. The commencement date of the examination has yet to be established, but CalOptima expects to begin receiving data requests soon.

B. Regulatory Notices of Non-Compliance

1. CalOptima did not receive any notices of non-compliance from its regulators for the months of July and August 2019.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring: Medi-Cal [a\]

- Medi-Cal: Professional Claims

| Month | Paid Claims Timeliness | Paid Claims Accuracy | Denied Claims Timeliness | Denied Claims Accuracy |
|---|---|---|---|---|
| March 2019 | 100% | 100% | 100% | 100% |
| April 2019 | 100% | 100% | 100% | 100% |
| May 2019 | 100% | 100% | 100% | 100% |

➢ For the May file review of Medi-Cal claims, CalOptima's Claims department received a 100% compliance score for the sixty (60) claims selected for a focused review as well as a 100% compliance score for timeliness based on the overall universe of paid and denied claims.



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- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

| Month | Paper PDRs Acknowledged within ≤ 15 Business Days | PDRs Resolved within ≤ 45 Business Days | Accurate PDR Determinations | Clear and Specific PDR Resolution Language | Interest Accuracy and Timeliness within ≤ 5 Business Days |
|---|---|---|---|---|---|
| March 2019 | 100% | 98% | 85% | 100% | 95% |
| April 2019 | 100% | 100% | 100% | 100% | 100% |
| May 2019 | 100% | 100% | 93% | 100% | 50% |

- ➢ For the May file review of Medi-Cal PDRs, CalOptima's Claims department received a compliance score of 89% for timeliness based on the overall universe of PDRs.

- ➢ The lower compliance score of 93% for accuracy of PDRs for May 2019 was due to multiple claims upheld in error based on a focused review of forty (40) PDRs.

- ➢ The lower compliance score of 50% for interest accuracy and timeliness for May 2019 was due to one (1) adjusted claim that was underpaid based on a review of two (2) PDRs.

- ➢ CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of PDRs. The A&O department continues to work with the Claims department 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 accurate processing of PDRs within regulatory requirements.

- Medi-Cal Grievance & Appeals Resolution Services (GARS): Standard Grievances

| | Classification Score | Grievance Acknowledged ≤ 5 Calendar Days of Receipt | | | |
|---|---|---|---|---|---|
| March 2019 | 100% | 100% | 100% | 80% | |
| April 2019 | Pending | Pending | Pending | Pending | Pending |
| May 2019 | Pending | Pending | Pending | Pending | |



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- No significant trends identified at this time.

2. Internal Monitoring: OneCare [a\]

- OneCare Claims: Professional Claims

| Month | Paid Claims Timeliness | Paid Claims Accuracy | Denied Claims Timeliness | Denied Claims Accuracy |
|---|---|---|---|---|
| March 2019 | 100% | 100% | 100% | 100% |
| April 2019 | 100% | 100% | 100% | 100% |
| May 2019 | 100% | 100% | 100% | 100% |

- For the May file review of OneCare claims, CalOptima's Claims department received a compliance score of 100% based on a focused review of twenty (20) claims for timeliness and accuracy and a review of the overall universe of paid and denied claims for timeliness.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

| Month | Resolution Timeliness | Accurate PDR Determinations | Clear and Specific PDR Resolution Language |
|---|---|---|---|
| March 2019 | Nothing to Report | Nothing to Report | Nothing to Report |
| April 2019 | Nothing to Report | Nothing to Report | Nothing to Report |
| May 2019 | 100% | 100% | 100% |

- For the May file review of OneCare PDRs, CalOptima's Claims department received a compliance score of 100% based on a focused review of one (1) PDR and a review of the overall universe of PDRs for timeliness.



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- OneCare GARS: Written Standard Grievances

| Month | Classification Score | Grievance Acknowledged ≤ 5 Calendar Days of Receipt | Language Preference | Member Notice Content | Resolution of Grievances Resolved ≤ 30 Calendar Days of Receipt |
|---|---|---|---|---|---|
| March 2019 | 100% | 100% | 100% | 0% | |
| April 2019 | Pending | Pending | Pending | Pending | Pending |
| May 2019 | Pending | Pending | Pending | Pending | Pending |

➢ No significant trends to report at this time.

3. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect Claims: Professional Claims

| Month | Paid Claims Timeliness | Paid Claims Accuracy | Denied Claims Timeliness | Denied Claims Accuracy |
|---|---|---|---|---|
| March 2019 | 100% | 100% | 100% | 100% |
| April 2019 | 90% | 100% | 100% | 90% |
| May 2019 | 100% | 100% | 100% | 90% |

➢ For the May file review of OneCare Connect claims, CalOptima's Claims department:
  - Received a compliance score of 98% for timeliness based on the overall universe of paid and denied claims.
  - Based on a focused review of twenty (20) claims, the lower compliance score of 90% for denied claims accuracy was due to one (1) inaccurate claim.

➢ CalOptima's Audit & Oversight (A&O) department issued a request for corrective action plan (CAP) for deficiencies identified during the review of paid and denied claims. The A&O department continues to work with the Claims department 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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- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

| Month | Determination Accuracy | Resolution Timeliness | Letter Accuracy | Check Lag |
|---|---|---|---|---|
| March 2019 | 100% | 83% | 100% | N/A |
| April 2019 | 100% | 100% | 100% | N/A |
| May 2019 | 100% | 100% | 100% | N/A |

➢ For the May file review of OneCare Connect PDRs, CalOptima's Claims department received a compliance score of 100% based on a focused review of two (2) PDRs and a review of the overall universe of PDRs for timeliness.

- OneCare Connect GARS: Written Standard Grievances

| Month | Classification Score | Grievance Acknowledged ≤ 5 Calendar Days of Receipt | Language Preference | Member Notice Content | Resolution of Grievances Resolved ≤ 30 Calendar Days of Receipt |
|---|---|---|---|---|---|
| March 2019 | 100% | 100% | 90% | 30% | |
| April 2019 | Pending | Pending | Pending | Pending | |
| May 2019 | Pending | Pending | Pending | Pending | |

➢ No significant trends to report at this time.

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4. Internal Monitoring: PACE [a\]

- PACE Claims: Professional Claims

| Month | Paid Claims Accuracy | Paid Claims Timeliness | Denied Claims Accuracy | Denied Claims Timeliness |
|---|---|---|---|---|
| March 2019 | 100% | 100% | 90% | 100% |
| April 2019 | 100% | 100% | 100% | 100% |
| May 2019 | 100% | 100% | 100% | 100% |

➢ For the May file review of PACE claims, CalOptima's Claims department received a 100% compliance score for the twenty (20) claims selected for a focused review as well as a 100% compliance score for timeliness based on the overall universe of paid and denied claims.

- PACE Claims: Provider Dispute Resolutions (PDRs)

| Month | Determination Accuracy | Letter Accuracy | Resolution Timeliness | Check Lag |
|---|---|---|---|---|
|  | 100% | 100% | 100% | N/A |
|  | 100% | 100% | 100% | N/A |
|  | 100% | 100% | 100% | N/A |

➢ For the May file review of PACE PDRs, CalOptima's Claims department received a compliance score of 100% for timeliness based on the overall universe of PDRs and based on the focused review of two (2) PDRs.



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- PACE: Service Delivery Requests (SDRs)

| Month | SDR Denials | SDR Approvals |
|---|---|---|
| March 2019 | 100% | 100% |
| April 2019 | 0% | 100% |
| May 2019 | Nothing to Report | 67% |

- For the March file review of PACE SDRs, CalOptima's PACE department received a compliance score of 100% for timeliness based on the overall universe of SDRs and based on the focused review of six (6) SDRs.

- For the April file review of PACE SDRs, CalOptima's PACE department received a compliance score of 50% for timeliness based on the overall universe of SDRs.

- The lower compliance score of 0% for SDR denials for April 2019 was due to missing documentation based on a review of three (3) SDRs.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of SDRs. The A&O department continues to work with the PACE department 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 accurate processing of SDRs within regulatory requirements.

- For the May file review of PACE SDRs, CalOptima's PACE department received a compliance score of 67% for timeliness based on the overall universe of SDRs.

- The lower compliance score of 0% for SDR denials for May 2019 was due to missing documentation based on a review of nine (9) SDRs. CalOptima's A&O department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of SDRs. The A&O department continues to work with the PACE department 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 accurate processing of SDRs within regulatory requirements.


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5. Health Network Monitoring: Medi-Cal

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

| Month | Timeliness for Urgent | Clinical Decision Making (CDM) for Urgent | Letter Score for Urgent | Timeliness for Routine | Timeliness for Denials | CDM for Denials | Letter Score for Denials | Timeliness for Modified | CDM for Modified | Letter Score for Modified | Timeliness for Deferrals | CDM for Deferrals | Letter Score for Deferrals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| March 2019 | 68% | 84% | 85% | 73% | 74% | 87% | 86% | 76% | 84% | 85% | 71% | 67% | 73% |
| April 2019 | 87% | 85% | 85% | 82% | 88% | 84% | 85% | 89% | 84% | 83% | 100% | 78% | 80% |
| May 2019 | 62% | 87% | 81% | 76% | 78% | 91% | 91% | 64% | 86% | 87% | 80% | 87% | 92% |

- ➢ Based on a focused review of select files, the lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision
  - Failure to meet timeframe for provider initial notification to the requesting provider
  - Failure to meet timeframe for provider written notification
  - Failure to meet timeframe for member delay notification

- ➢ Based on a focused review of select files, the lower letter scores were due to the following reasons:
  - Failure to provide letter with description of services in lay language
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to include name and contact information for health care professional responsible for the decision to deny
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer

- ➢ Based on the overall universe of Medi-Cal authorizations for April 2019, CalOptima's health networks received an aggregate compliance score of 91% for timely processing of routine authorization requests and a compliance score of 91% 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 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.



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- Medi-Cal Claims: Professional Claims

| Month | Paid Claims Timeliness | Paid Claims Accuracy | Denied Claims Timeliness | Denied Claims Accuracy |
|---|---|---|---|---|
| March 2019 | 93% | 82% | 98% | 69% |
| April 2019 | 99% | 84% | 98% | 87% |
| May 2019 | 99% | 88% | 99% | 88% |

- ➢ No significant trends were identified from the focused file reviews of Medi-Cal claims.

- ➢ Based on the overall universe of Medi-Cal claims for April 2019, CalOptima's health networks received an overall compliance score of 88% 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.

6. Health Network Monitoring: OneCare

- OneCare Utilization Management: Prior Authorization Requests

| Month | Timeliness for Expedited Initial Organization Determinations (EIOD) | Clinical Decision Making for EIOD | Letter Score for EIOD | Timeliness for Standard Organization Determinations (SOD) | Letter Score for SOD | Timeliness for Denials | Clinical Decision Making for Denials | Letter Score for Denials |
|---|---|---|---|---|---|---|---|---|
| March 2019 | 78% | 100% | 89% | 88% | 85% | 50% | 83% | 83% |
| April 2019 | 98% | 100% | 90% | 97% | 92% | 100% | 78% | 95% |
| May 2019 | 83% | 100% | 93% | 87% | 93% | 78% | 67% | 96% |

- ➢ The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision
  - Failure to meet timeframe for member notification



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– Failure to meet timeframe for provider notification
– Failure to meet timeframe for member delay notification (expedited)

➢ The lower scores for clinical decision making were due to the following reasons:
– Failure to obtain adequate clinical information
– Failure to cite criteria for decision

➢ Based on the overall universe of OneCare authorization requests for CalOptima's health networks for the month of April 2019, CalOptima's health networks received an overall compliance score of 86% for timely processing of standard Part C authorization requests and 80% 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.

- OneCare Claims: Professional Claims

| Month | Paid Claims Timeliness | Paid Claims Accuracy | Denied Claims Timeliness | Denied Claims Accuracy |
|---|---|---|---|---|
| March 2019 | 93% | 96% | 100% | 92% |
| April 2019 | 98% | 92% | 100% | 88% |
| May 2019 | 100% | 98% | 98% | 90% |

➢ Based on a focused review of select files, the compliance rate for denied claims timeliness decreased from 100% in April 2019 to 98% in May 2019 due to untimely processing of multiple 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 training, process development, system enhancements, ongoing inline monitoring, and



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policy revisions to ensure timeliness and accuracy of claims processing within regulatory requirements.

- Based on the overall universe of OneCare claims for CalOptima's health networks for the month of April 2019, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
  - 85% for non-contracted clean claims paid or denied within 30 calendar days of receipt
  - 88% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt

7. Health Network Monitoring: OneCare Connect

- OneCare Connect Utilization Management: Prior Authorization Requests

| Month | Timeliness for Urgents | Clinical Decision Making (CDM) for Urgents | Letter Score for Urgents | Timeliness For Routine | Letter Score for Routine | Timeliness for Denials | CDM for Denials | Letter Score for Denials | Timeliness for Modifieds | CDM for Modifieds | Letter Score for Modifieds |
|---|---|---|---|---|---|---|---|---|---|---|---|
| March 2019 | 78% | 75% | 81% | 73% | 91% | 58% | 78% | 85% | 55% | 76% | 75% |
| April 2019 | 83% | 84% | 84% | 88% | 87% | 92% | 85% | 79% | 94% | 81% | 78% |
| May 2019 | 71% | 75% | 82% | 70% | 87% | 83% | 83% | 82% | 82% | 83% | 70% |

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision
  - Failure to meet timeframe for member notification
  - Failure to meet timeframe for provider initial notification
  - Failure to meet timeframe for provider written notification

- The lower scores for clinical decision making were due to the following reasons:
  - Failure to obtain adequate clinical information
  - Failure to cite criteria for decision

- The lower letter scores were due to the following reasons:
  - Failure to provide information on how to file a grievance
  - Failure to provide letter in member's primary language
  - Failure to provide language assistance program (LAP) insert in approved threshold languages
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide letter with description of services in lay language
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer
  - Failure to include name and contact information for health care professional responsible for the decision to deny



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- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for April 2019, CalOptima's health networks received an overall compliance score of 91% for timely processing of routine authorization requests and 88% 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 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 |
|---|---|---|---|---|
| March 2019 | 96% | 91% | 100% | 84% |
| April 2019 | 99% | 94% | 99% | 89% |
| May 2019 | 100% | 99% | 99% | 88% |

- Based on a focused review of select files, the compliance rate for denied claims accuracy decreased from 89% in April 2019 to 88% in May 2019 due to missing documents that are required for processing accurate payment on claims.

- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for March 2019, CalOptima's health networks received the following overall compliance scores:
  - 89% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  - 90% 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



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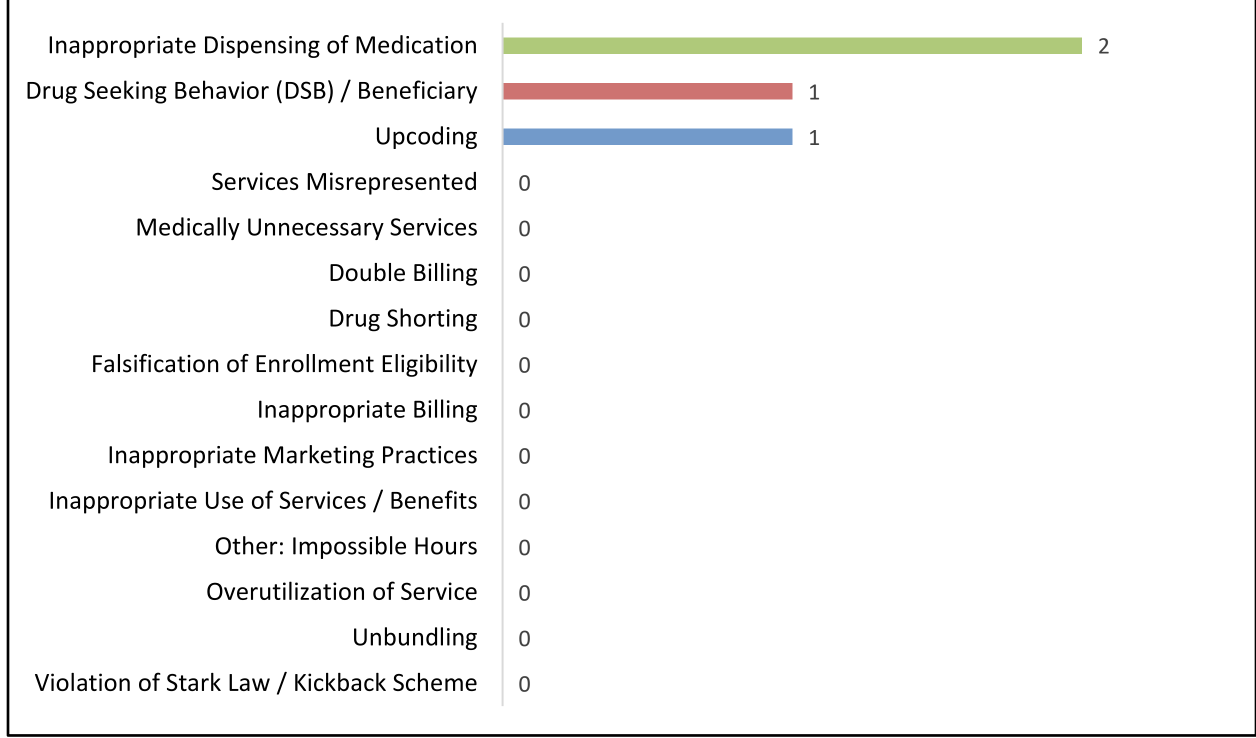
with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in July 2019)





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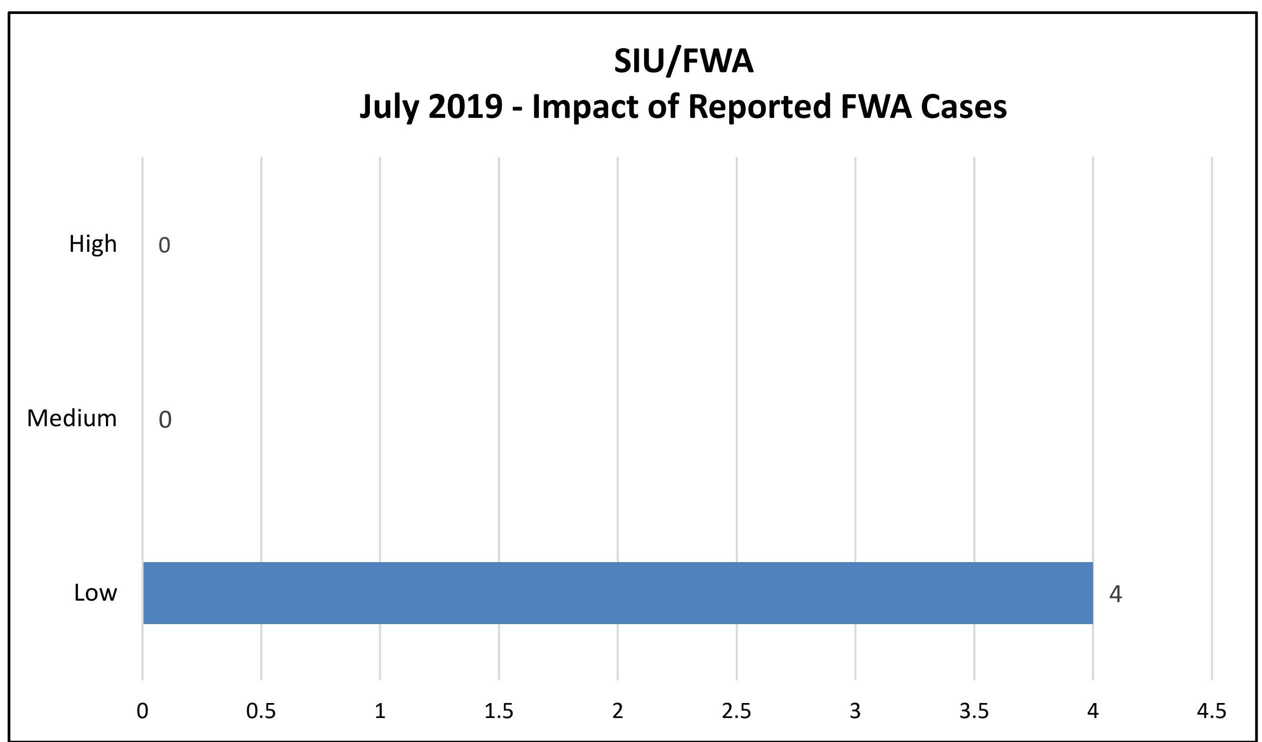
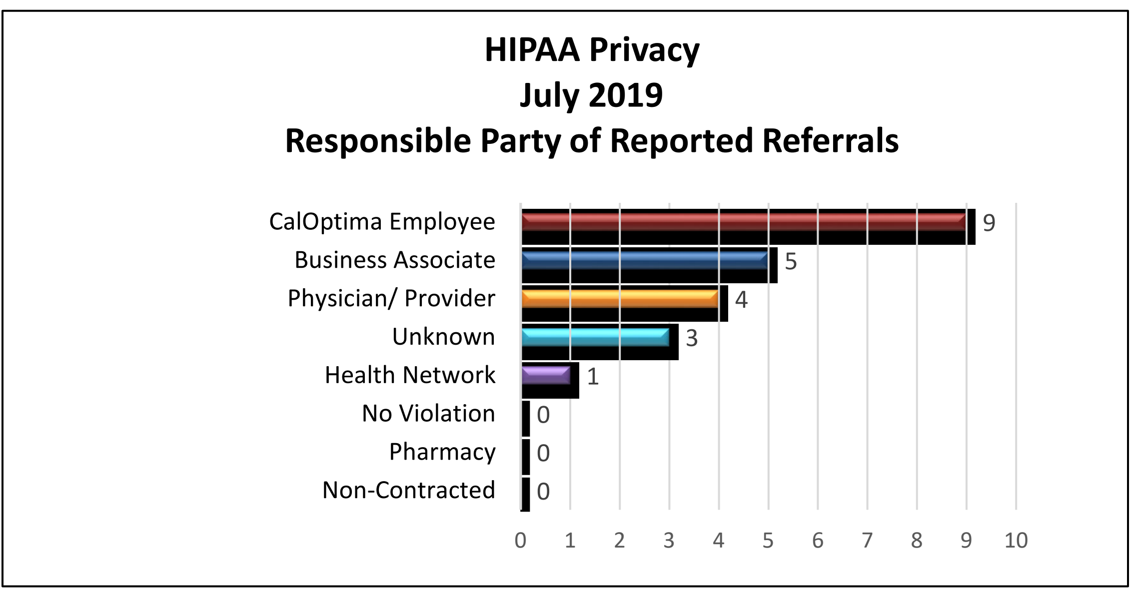



E. Privacy Update (July 2019)



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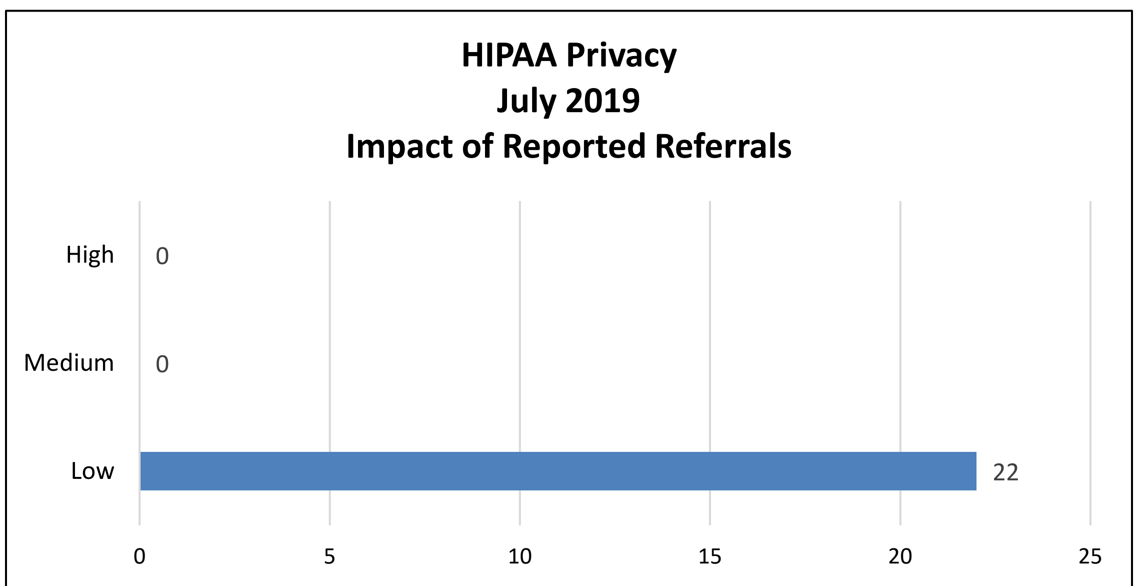


| Total Number of Referrals Reported to DHCS (State) | 22 |
|---|---|
| Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR) | 0 |
| **Total Number of Referrals Reported** | **22** |


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MEMORANDUM

August 5, 2019

**To:** CalOptima

**From:** Akin Gump Strauss Hauer & Feld, LLP

**Re:** August Board of Directors Report

The past several weeks saw a frenzy of activity on Capitol Hill as Congress approved a sweeping budget agreement and key committees advanced health care cost legislation addressing surprise billing and prescription drug pricing. With appropriations work still unfinished and congressional leaders eyeing fall action on health care, lawmakers will face a busy agenda when they return to Washington after Labor Day. This report provides an update on legislative activities through August 5, 2019.

**FY 2020 Budget and Appropriations**

Following prolonged negotiations between House Speaker Nancy Pelosi (D-CA) and Treasury Secretary Steven Mnuchin, President Trump on August 2 signed into law a two-year, $2.7 trillion budget deal that increases defense and non-defense spending caps while also suspending the debt ceiling through July 2021. The package, H.R. 3877, would boost defense spending by $22 billion in fiscal year (FY) 2020, a smaller increase than initially sought by the President, while nondefense spending would increase by $27 billion. The budget deal cleared the House on a 284-149 vote, with 132 Republicans voting against the agreement. The package passed 67-28 in the Senate, where Majority Leader Mitch McConnell (R-KY) had been pressing GOP Members to support the deal.

While the budget agreement prevents $126 billion in automatic spending cuts under sequestration, Congress must still address the FY 2020 appropriations bills before the end of the fiscal year on September 30, a process that comes with its own complications. The Senate Appropriations Committee has yet to mark up any of the 12 individual appropriations measures, and Chairman Richard Shelby (R-AL) acknowledged that that appropriators are still working through partisan differences on topline spending levels for the bills. He has suggested that the Senate could package the FY 2020 Defense, Labor-Health and Human Services, and Energy-Water spending measures together for a floor vote before the end of September. With such a small window for action, most observers expect that at least a partial continuing resolution (CR) will be needed to prevent a government shutdown.

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**Health Care Cost Legislation**

Committees continue to advance health care cost containment legislation, with the hope that surprise billing and drug pricing legislation will receive floor consideration this fall. On July 17, the House Energy and Commerce Committee advanced its surprise billing proposal, the No Surprises Act. Like the Senate Health, Education, Labor and Pensions (HELP) Committee's bill, the Lower Health Care Costs Act of 2019, the No Surprises Act holds patients harmless for out-of-network emergency care and in situations where they cannot reasonably choose a provider. The bill also includes some reporting requirements for air ambulance providers but does not apply other surprise billing protections to this sector. The bill initially utilized a benchmark payment approach based on the median in-network rate. In response to concerns from several Members, however, the Committee adopted an amendment at markup from Reps. Raul Ruiz (D-CA) and Larry Bucshon (R-IN) to add an independent dispute resolution (IDR) process as a backstop to the benchmark approach.

The Energy and Commerce Committee also advanced a package of drug price transparency bills during the July 17 markup. The package includes FAIR Drug Pricing Act (H.R. 2296) along with provisions from the Public Disclosures of Drug Discounts Act (H.R. 2115), the Prescription Pricing for the People Act (H.R. 2376), the Sunshine for Samples Act (H.R. 2064), and the Drug Price Transparency Act (H.R. 2087). Versions of many of these provisions were included in the House Ways and Means Committee's Prescription Drug STAR Act (H.R. 2113), which was reported out of that Committee on April 9.

On the Senate side, the Finance Committee reported out its much-awaited drug pricing package on July 25. The Prescription Drug Pricing Reduction Act, which was marked up in conceptual form, includes more than two dozen proposals intended to lower drug costs in Medicare Part B, Medicare Part D, and Medicaid. Among the more notable provisions is a $3,100 cap on out-of-pocket costs for Part D beneficiaries and a provision that would require drug manufacturers to refund Medicare for any price increase greater than inflation in Part B or Part D. The package also sets a maximum add-on payment amount for drugs, biologics, and biosimilars in Part B. With respect to Medicaid, the package proposes to:

- Increase the Medicaid inflation rebate cap from 100 percent to 125 percent;
- Remove authorized generics from the calculation of Average Manufacturer Price (AMP) under the Medicaid Drug Rebate Program;
- Require the Department of Health and Human Services (HHS) to audit the calendar quarter drug pricing information reported by manufacturers;

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- Allow states to include any drug, biologic, or insulin product as part of a bundled payment if it is provided on an outpatient basis as part of physicians' services or hospital outpatient services; and
- Allow states to establish risk-sharing value-based agreements with manufacturers for potentially curative one-time treatments.

The package passed over the objections of a majority of Republicans on the Committee, who expressed concerns that the inflationary rebates amount to price controls. The Committee also rejected an amendment from Sen. Debbie Stabenow (D-MI) to allow the government to directly negotiate drug prices for Medicare Part D, as well as an amendment from Sen. Pat Toomey (R-PA) to block implementation of the Administration's International Pricing Index (IPI) Model. The Chairman and Ranking Member are expected to add several other provisions to the bill before it is considered in tandem with the HELP Committee's Lower Health Care Costs Act on the floor. Senate Republican leadership recently initiated a process known as "hotlining" in order to gauge support for the HELP Committee bill, finding that more than a dozen Republicans were prepared to place "holds" on the legislation due to concerns over the payment methodology in the legislation. In particular, several senators are pushing HELP Chairman Alexander to add an arbitration component to the bill.

We expect a very active fall as House and Senate leadership attempt to find a path forward on drug pricing and surprise billing, among other high-profile issues.

**Medicaid Developments**

The past month saw several notable developments related to the Medicaid program. On July 27, the Centers for Medicare and Medicaid Services (CMS) confirmed that the Administration will not allow states to receive enhanced federal matching funds for partial Medicaid expansions. The announcement continues the partial expansion policy adopted under the Obama Administration, though a CMS spokesperson attributed the Trump Administration's opposition to concern that approvals of partial Medicaid expansions "would invite continued reliance on a broken and unsustainable Obamacare system."

On July 29, the U.S. District Court for the District of Columbia ruled against a Section 1115 waiver under which New Hampshire would impose a 100-hour-a-month work requirement for Medicaid expansion beneficiaries. Judge James Boasberg, an Obama appointee, wrote that CMS failed to demonstrate how the waiver would advance the "core objective" of the Medicaid program in providing "medical care to the needy."

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On the congressional front, Reps. Cheri Bustos (D-IL), Jim McGovern (D-MA), Tom Cole (R-OK), and Cathy McMorris Rodgers (R-WA) on July 25 introduced the Social Determinants Accelerator Act (H.R. 4004), which would provide planning grants to help communities improve health outcomes by addressing social determinants of health, such as stable housing and reliable transportation. Specifically, the bill would authorize $25 million in grants to state, local, and Tribal governments to develop Social Determinants Accelerator Plans that would target high-need Medicaid patients.

Finally, the House voted unanimously on July 30 to pass a short-term extension of the Certified Community Behavioral Health Clinic (CCBHC) demonstration, which provides enhanced Medicaid payments to clinics providing behavioral health and substance use disorder services in eight participating states. The bill, which was passed by the Senate on July 26, now heads to the President. House Energy and Commerce Committee Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR) are still pushing for a long-term extension of the demonstration, which now expires on September 13, 2019.

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**CALOPTIMA**
**LEGISLATIVE REPORT**
By Don Gilbert and Trent Smith
August 13, 2019

The Legislative Session is in the home stretch. Legislators returned to Sacramento on August 12 to begin the final month of work before adjourning for the year on September 13. For the balance of August, most of the focus will be centered on the Appropriations Committees in both the Assembly and the Senate. These committees focus on the potential cost legislative proposals may have on the State. These committees are the last stop before bills reach the respective floors of the Senate and Assembly. Bills deemed to have even a minimal cost to the State are held on the Suspense File. At the end of August the Appropriations Committees in each house will determine which bills are released from the Suspense File and which bills are held in committee. Bills held on the Suspense File are dead and cannot be pursued further. Decisions on which bills move and which are held on the Suspense File are made by the respective Chairs and leadership of each house. Bills are often held on the Suspense File for political and policy reasons rather than fiscal impacts to the State.

Legislators, lobbyists, and staff pay very close attention to the Suspense File hearings to learn the fate of many important bills, some of which have been moved though the legislative process as "works in progress" with promises from the author and sponsors to address concerns put forth by opponents. The Appropriations Committees usually hold more bills from the other house than their own, which means many more bills will likely die in late August compared to the Suspense File hearings when committees reviewed bills authored by members of their own house.

Once the Appropriations Committees complete their work both the Senate and Assembly Floors will meet almost on a daily basis until September 13. During the last week of session, floor hearings will often go well into the evening. This year, the last night of session could go into the early morning hours.

AB 1642 by Assemblyman Wood, which we previously reported on, is one of the bills that will be considered in coming weeks in the Senate Appropriations Committee. As you may recall, this measure proposes a number of changes to the Medi-Cal program intended to improve the delivery and utilization of services, including changes related to time and distance standards and preventative services and outreach. This bill also codifies the Department of Health Care Services' (DHCS) authority to impose administrative and financial sanctions on Medi-Cal managed care plans (MCP). Much of AB 1642 comes from recommendations made in the Bureau of State Audits audit focused on Medi-Cal MCP provisions of pediatric preventive services and access to care. The author's stated goal is to improve timely access to medically necessary services and preventative care and to improve accountability in Medi-Cal MCP performance. The fate of AB 1642 will be known in late August when the Senate Appropriations Committee has its Suspense File hearing.

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On July 24 DHCS hosted a stakeholder meeting to discuss the Governor's Executive Order to consolidate all prescription drug purchasing powers into the hands of the State. The plan is known as the Medi-Cal Pharmacy Carve Out. As a reminder, on January 7, 2019, right after being sworn into office, Governor Newsom issued an Executive Order for the purposes of achieving cost savings for drug purchases made by the State. A primary component of the Executive Order requires that all Medi-Cal pharmacy services be transitioned from managed care (MC) to fee-for-service (FFS) under the State by January 1, 2021.

In the State Budget passed earlier this year, the Legislature required further study of the Executive Order and stakeholder meetings. The Governor's office estimates the consolidated purchasing of prescription drugs will allow the State to achieve better drug pricing, potentially saving the State $393 million. However, health plans, especially County Organized Health Systems (COHS) like CalOptima are concerned that the proposed pharmacy carve out will inhibit the proper coordination of health care, a core mission of a COHS. There are also concerns over the timing of drug authorizations for new prescriptions. Unfortunately, the Governor appears to have the power to move forward with the pharmacy carve out without legislative approval. Therefore, Legislators who share the concerns put forth by some of the health plans appear to have little power to influence the plan. More details will emerge later this year as DHCS continues meeting with stakeholders.

The State Auditor recently released an audit report that, while not directly focused on CalOptima, speaks favorable about the COHS and their ability to deliver reliable health care. The report focused on the delivery of timely and convenient healthcare in rural counties in Northern California served by two commercial health plans. The audit found that the Medi-Cal enrollees in these counties had fewer options and had to travel further distances to receive their health care compared to enrollees in similar Northern California counties served by Partnership Health Plan, which is COHS. In her report, the State Auditor highlighted the fact that COHS do not have to distribute profits to shareholder or owners, leaving more money to directly serve Medi-Cal enrollees. Furthermore, the Auditor attributed the better service provided by the COHS plan to the fact that COHS are governed by a board of directors consisting of appointed local officials and providers.

The audit report went so far as to recommend that the Medi-Cal enrollees in the counties studied in the audit could be better served by a COHS and that DHCS should assist counties to transition to a COHS model.

The audit report states, "We believe that DHCS could improve the future access to managed care services of the Regional Model beneficiaries by assisting counties in transitioning from the Regional Model to a county organized health system (COHS). Partnership -- the health plan that currently serves eight of the 28 rural expansion counties and has generally provided adequate

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access within those counties -- is a COHS that non-rural expansion counties established before the rural expansion.  In contrast to the Regional Model, a COHS uses a single health plan to deliver services to all of its beneficiaries. Consequently, these beneficiaries can receive care from the same network of providers unlike in the Regional Model in which the two health plans frequently contract with different providers.  Further, a COHS operates under the direct influence of county officials who make up a portion of its board of commissioners.  The counties are, therefore, better able to direct the COHS to use its resources to address the specific needs of their beneficiaries.  Although many variables affect health plans' abilities to establish provider networks that deliver acceptable access to care, a COHS might enable better access to care in the Regional Model counties."

Again, while the audit report does not specially focus on CalOptima  it does favorably highlight the superior care provided in the COHS model compared to other Medi-Cal managed care models.

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# Board of Directors Meeting
# September 5, 2019

## CalOptima Community Outreach Summary — August 2019

**Background**
CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors as indicated pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

**CalOptima Community Events Update**
The Community Relations department participated in the SoCal Spring Health Fair hosted by the Syrian American Medical Society on Saturday, June 15, 2019 in Anaheim. This event provided CalOptima an opportunity to serve our members who speak Arabic, one of our threshold languages. In addition to hosting a resource table to share information about Medi-Cal benefits, stroke and thyroid health screenings were also provided to support our members' health care needs.

On Saturday, August 25, 2019, CalOptima attended a Health Fair hosted in collaboration with Blessed Sacrament Church and St. Joseph Hospital. This event was open to church members and the community at large. At this event, CalOptima hosted a resource table and provided bone density screenings to attendees. This event provided an opportunity for CalOptima to expand our services to the faith-based communities and hard to reach populations.

As the public health insurance plan, CalOptima will continue to explore opportunities to provide health screenings at community resource fairs in an effort to reduce barriers and improve access to health care services.

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For additional information or questions, please contact Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

**Summary of Public Activities**
**During August 2019, CalOptima participated in 41 community events, coalitions and committee meetings:**

**TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS**

| Date | Events/Meetings |
|---|---|
| 8/01/19 | • Orange County Homeless Providers Forum |
| 8/02/19 | • Covered Orange County General Meeting<br>• Help Me Grow Advisory Meeting |
| 8/05/19 | • Orange County Health Care Agency Mental Health Services Act Steering Committee |
| 8/06/19 | • Collaborative to Assist Motel Families Meeting |
| 8/07/19 | • Orange County Aging Services Collaborative Meeting<br>• Orange County Aging Services Initiatives Meeting<br>• Anaheim Human Services Network Meeting |
| 8/08/19 | • Kid Healthy Community Advisory Committee Meeting<br>• Orange County Women's Health Project Advisory Meeting |
| 8/12/19 | • Fullerton Collaborative Meeting<br>• Orange County Veterans and Military Families Collaborative Children and Family Workgroup Meeting |
| 8/13/19 | • Orange County Strategic Plan for Aging — Social Engagement Committee Meeting<br>• San Clemente Youth Wellness and Prevention Coalition |
| 8/14/19 | • Buena Park Collaborative Meeting<br>• Orange County Strategic Plan for Aging — Health Care Subcommittee Meeting<br>• Orange County Communication Workgroup Meeting<br>• Anaheim Homeless Collaborative |
| 8/15/19 | • Cal State Fullerton Center for Healthy Neighborhoods Community Advisory Board Meeting<br>• Surf City Senior Providers Networking Meeting<br>• Orange County Children's Partnership Committee Meeting |
| 8/20/19 | • Placentia Community Collaborative Meeting |
| 8/21/19 | • Disability Coalition of Orange County Meeting<br>• Orange County Communication Workgroup Meeting |

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| | • La Habra Community Collaborative Meeting<br>• Covered California Steering Committee Meeting<br>• Orange County Promotoras<br>• Minnie Street Family Resource Center Professional Roundtable |
| 8/22/19 | • Orange County Care Coordination for Kids Meeting |
| 8/26/19 | • Community Health Research and Exchange Meeting |
| 8/27/19 | • Orange County Senior Roundtable Meeting |
| 8/28/19 | • Connection Café |

**TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS**

| Date | # Staff to Attend | Events/Meetings |
|---|---|---|
| 8/03/19 | 2 | • Back to School Bash hosted by Santa Ana Unified School District (Sponsorship Fee: $1,000 included an exhibit table for outreach at the event) |
| | 2 | • Intergenerational Health Fair hosted by KidWorks |
| 8/10/19 | 2 | • Health and Wellness Fair hosted by City of Fullerton (Registration Fee: $100 included an exhibit table for outreach at the event) |
| 8/11/19 | 2 | • Back to School Block Party and Resource Fair hosted by Boys and Girls Club of Garden Grove and Orange County Grace Church |
| 8/16/19 | 1 | • Annual Senior Health Fair hosted by the Office of Congresswoman Linda Sanchez |
| | 1 | • Health Fair at Triangle Terrace hosted by Living Opportunities Management Company |
| 8/17/19 | 1 | • Super Senior Saturday hosted by City of Buena Park Senior Center (Registration Fee: $150 included an exhibit table for outreach at the event) |
| 8/25/19 | 3 | • Health Fair at Blessed Sacrament Church hosted by St. Joseph Hoag Health |
| 8/29/19 | 1 | • Veterans Resource Fair hosted by Saddleback College |

**CalOptima provided one endorsement during this reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).**

1. Provide a Letter of Support for Orange County Health Care Agency's Stigma Free Orange County social media campaign.

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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.
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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.

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

| **September** | | | | |
|---|---|---|---|---|
| **Date and Time** | **Event Title** | **Event Type/Audience** | **Staff/Financial Participation** | **Location** |
| Tuesday, 9/3<br>9:30-11am | ++Collaborative to Assist Motel Families | Steering Committee Meeting: Open to Collaborative Members | N/A | Downtown Anaheim Community Center<br>250 E. Center St.<br>Anaheim |

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| Thursday 9/5<br>9-11am | ++Homeless Provider Forum | Steering Committee Meeting: Open to Collaborative Members | N/A | Covenant Presbyterian Church<br>1855 Orange Olive Rd.<br>Orange |
| Thursday, 9/5<br>9-10:30am | ++Refugee Forum of Orange County | Steering Committee Meeting: Open to Collaborative Members | N/A | Access California Services<br>631 S. Brookhurst St.<br>Anaheim |
| Thursday, 9/5<br>5-6:30pm | *Health Education Workshops<br>Shape Your Life | Open to the Public<br>Registration required. | N/A | Ponderosa Family Resource Center<br>320 E. Orangewood Ave.<br>Anaheim |
| Saturday, 9/7<br>9am-1pm | +Huntington Beach Council on Aging<br>Senior Saturday Community Health Festival | Health/Resource Fair<br>Open to the Public | Sponsorship<br>$850<br>2 Staff | Pier Plaza<br>Downtown<br>Huntington Beach |
| Saturday, 9/7<br>3:30-8:30pm | +Vietnamese American Youth Organization<br>Mid-Autumn Moon Festival | Health/Resource Fair<br>Open to the Public | Sponsorship<br>$1,000<br>5 Staff | Atlantis Play Center<br>13630 Atlantis Way<br>Garden Grove |
| Monday, 9/9<br>1-2:30pm | +OC Veterans and Military Families Collaborative | Steering Committee Meeting: Open to Collaborative Members | N/A | Child Guidance Center<br>525 N. Cabrillo Park Dr.<br>Santa Ana |
| Monday, 9/9<br>2:30-3:30pm | ++Fullerton Collaborative | Steering Committee Meeting: Open to Collaborative Members | N/A | Fullerton Library<br>353 W. Commonwealth Ave.<br>Fullerton |
| Tuesday, 9/10<br>9-10:30am | ++OC Strategic Plan for Aging<br>Social Engagement Committee | Steering Committee Meeting: Open to Collaborative Members | N/A | Alzheimer's OC<br>2515 McCabe Way<br>Irvine |
| Tuesday, 9/10<br>10-11:30am | ++OC Cancer Coalition Meeting | Steering Committee Meeting: Open to Collaborative Members | N/A | OC Cancer Society<br>1940 E. Deere Ave.<br>Santa Ana |

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| Tuesday, 9/10<br>3:30-5:30pm | ++San Clemente Youth Wellness and Prevention Coalition | Steering Committee Meeting: Open to Collaborative Members | N/A | 189 Avenida La Cuesta<br>San Clemente |
| Wednesday, 9/11<br>10-11am | ++Buena Park Collaborative | Steering Committee Meeting: Open to Collaborative Members | N/A | Buena Park Library<br>7150 La Palma Ave.<br>Buena Park |
| Wednesday, 9/11<br>12-1:30pm | ++Anaheim Homeless Collaborative | Steering Committee Meeting: Open to Collaborative Members | N/A | Anaheim Central Library<br>500 W. Broadway<br>Anaheim |
| Wednesday, 9/11<br>3:30-4:30pm | ++OC Communications Workgroup | Steering Committee Meeting: Open to Collaborative Members | N/A | Location varies |
| Thursday, 9/12<br>11:30am-12:30pm | ++Garden Grove Collaborative Meeting | Steering Committee Meeting: Open to Collaborative Members | N/A | Garden Grove Community Center<br>11300 Stanford Ave.<br>Garden Grove |
| Thursday, 9/12<br>12:30-1:30pm | ++Kid Health Advisory Committee Mtg | Steering Committee Meeting: Open to Collaborative Members | N/A | OneOC<br>1901 E. Fourth St.<br>Santa Ana |
| Thursday, 9/12<br>2:30-4:30pm | ++OC Women's Health Project Advisory Board Meeting | Steering Committee Meeting: Open to Collaborative Members | N/A | The Village<br>1505 E. 17th St.<br>Santa Ana |
| Thursday, 9/12<br>3:30-5:30pm | ++ State Council on Developmental Disabilities Regional Advisory Committee Meeting | Steering Committee Meeting: Open to Collaborative Members | N/A | State Council on Developmental Disabilities<br>2000 East Fourth St.<br>Santa Ana |
| Thursday, 9/12<br>5-6:30pm | *Health Education Workshops<br>Shape Your Life | Open to the Public<br>Registration required. | N/A | Ponderosa Family Resource Center<br>320 E. Orangewood Ave.<br>Anaheim |
| Friday, 9/13<br>9-10am | ++Orange County Diabetes Collaborative | Steering Committee Meeting: Open to Collaborative Members | N/A | Orange County Health Care Agency<br>1725 W. 17th St.<br>Santa Ana, |



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| Friday, 9/13<br>9:30-11:30am | ++Senior Citizens Advisory Council Board Meeting | Steering Committee Meeting: Open to Collaborative Members | N/A | Location varies |
| Saturday, 9/14<br>9am-4pm | +OC Iranian American Chamber of Commerce | Health/Resource Fair Open to the Public | Sponsorship<br>$2,600<br>3 Staff | Quail Hill Community Center<br>39 Shady Canyon Dr. Irvine |
| Saturday, 9/14<br>4-9pm | +Vietnamese Cultural Center Mid-Autumn Moon Festival | Health/Resource Fair Open to the Public | Sponsorship<br>$10,000<br>5 Staff | Mile Square Park<br>Freedom Hall<br>16801 Euclid St.<br>Fountain Valley |
| Tuesday, 9/17<br>9-11am | *CalOptima Community Alliances Forum | Community Presentation Open to the Public | N/A | Delhi Center<br>505 Central Ave.<br>Santa Ana |
| Tuesday, 9/17<br>10-11:30am | ++Placentia Community Collaborative | Steering Committee Meeting: Open to Collaborative Members | N/A | Trinity Center Placentia Presbyterian Church<br>849 Bradford Ave.<br>Placentia |
| Wednesday, 9/18<br>11am-1pm | ++Minnie Street Family Resource Center Professional Roundtable | Steering Committee Meeting: Open to Collaborative Members | N/A | Minnie Street Family Resource Center<br>1300 McFadden Ave.<br>Santa Ana |
| Wednesday, 9/18<br>1-4pm | ++Orange County Promotoras | Steering Committee Meeting: Open to Collaborative Members | N/A | Location Varies |
| Wednesday, 9/18<br>1:30-3pm | ++La Habra Move More, Eat Health Campaign | Steering Committee Meeting: Open to Collaborative Members | N/A | Friends of Family Community Clinic<br>501 S. Idaho St.<br>La Habra |
| Thursday, 9/19<br>8:30-10am | ++OC Children's Partnership Committee | Steering Committee Meeting: Open to Collaborative Members | N/A | Orange County Hall of Administration<br>10 Civic Center Plaza<br>Santa Ana |
| Thursday, 9/19<br>5:30-7pm | * Health Education Workshop Healthy Weight, Healthy You | Community Presentation Open to the Public Registration Required | N/A | Ponderosa Park Family Resource Center |

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*++ Meeting Attendee*

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| | | | | 320 E. Orangewood Ave.<br>Anaheim |
| Friday, 9/20<br>9am-12pm | +Sea Country Senior and Community Center<br>Senior Health Expo | Health/Resource Fair<br>Open to the public | Sponsorship<br>$700<br>2 Staff | Sea Country Senior and Community Center<br>24602 Aliso Creek Rd.<br>Laguna Niguel |
| Monday, 9/23<br>12:30-1:30pm | ++Stanton Collaborative | Health/Resource Fair<br>Open to the public | N/A | Stanton Civic Center<br>7800 Katella Avenue<br>Stanton |
| Tuesday, 9/24<br>7:30-9am | ++OC Senior Roundtable | Steering Committee Meeting: Open to Collaborative Members | N/A | Orange Senior Center<br>170 S. Olive<br>Orange |
| Tuesday, 9/24<br>2-4pm | ++Susan G. Komen OC Unidos Coalition Meeting | Steering Committee Meeting: Open to Collaborative Members | N/A | Susan G. Komen Office<br>2817 McGraw Ave.<br>Irvine |
| Thursday, 9/26<br>1-3pm | ++Orange County Care Coordination for Kids Meeting | Steering Committee Meeting: Open to Collaborative Members | N/A | Help Me Grow<br>2500 Redhill Ave.<br>Santa Ana |
| Thursday, 9/26<br>5:30-7pm | * Health Education Workshop<br>Healthy Weight, Healthy You | Community Presentation<br>Open to the Public<br>Registration Required | N/A | Ponderosa Park Family Resource Center<br>320 E. Orangewood Ave.<br>Anaheim |

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*++ Meeting Attendee*

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